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ABSTRACT

A collection of 12 lessons, this volume covers a wide range of concerns in mental health counseling. Each piece begins with an editorial comment, followed by an introduction which outlines the scope of the problem under consideration. The main body of each lesson presents an analysis of the subject under consideration. A list of further sources the reader can consult appears in the back. Questions based on the lesson, which can help the reader gauge how much of the material he or she has understood, are listed at the end of each article. Lessons in this volume are: "Diagnosis and Management of Substance Abuse" (Edward C. Senay), "Child Abuse, Sexual Abuse, and Neglect" (Penolope Krener), "Obsessive-Compulsive Disorder: New Findings" (Thomas R. Insel), "The Diagnosis and Treatment of Passive-Aggressive Personality Disorder" (Allen Frances and James Widiger), "An Update on Post-Traumatic Stress Disorder" (Marion E. Wolf and Giselle S. Mosnaim), "Therapeutic Approaches to Erotic Transference" (Glen O. Gabbard), "Forgiveness" (Robert J. McAllister), "The Risk of Diagnosing Physical Illness as Depression" (Mark S. Gold), "Understanding Shame" (Donald L. Nathanson), "The Psychotherapy of Depression" (Anthony Storr), "On the Efficacy of Psychotherapy" (Henry M. Bachrach), and "The Diagnosis and Treatment of Multiple Personality Disorder" (Richard P. Kluft). Includes an index. (RJM)

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Directions in Mental Health Counseling

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Directions in
Mental Health
Counseling

VOLUME 1 • LESSON 1

Diagnosis and Management of Substance Abuse

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VOL. 1, NO. 1

January 1991

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EDITOR'S NOTE

Substance abuse crosses all age, socioeconomic, and vocational boundaries. It may present as a primary disorder or as a complicating factor among patients with physical or mental disabilities who may have ready access to multiple prescription drugs. In this lesson, the author outlines the essentials of an effective history for substance abuse. One should determine the age of onset, as the earlier in life abuse began and the longer its duration, the more complications one may expect. Define the settings in which substance abuse is most likely to occur for each individual, e.g. alone, with others, or in the context of marital difficulties. In assessing the risk of withdrawal, carefully evaluate recent rates of substance use. Ask specific questions about specific substances, from alcohol and nicotine to cocaine and opioids.

Pay particular attention to the relationship between psychopathological symptoms and drug abuse. Inquire about the possible development of drug tolerance; to what degree the client is preoccupied with use of a specific drug; whether he or she feels or manifests loss of control with drug use; whether he or she has made efforts to decrease or stop drug use. Discover what "benefits" the client believes are derived from drug usage and what the motives are for currently seeking help. The nature, extent, and limitations of confidentiality should be explored and appropriate reassurance offered.

In coordinating a multi-disciplinary treatment plan, substance abuse should be viewed as a distinct entity in itself, while still giving due attention to the client's other problems. Concurrent medical and psychological disorders should be treated appropriately. Monitoring clients for drug use during treatment is important. Whenever possible, the client's family should be involved in the substance abuse rehabilitation program.

Each client must fully commit to treatment goals and recognize that the program will be long-term. Moreover, the client must have confidence that the professional team and community programs will be available to assist in the recovery process.

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Introduction

All counselors should know how to recognize and treat primarily or to effectively refer any client with a substance abuse disorder. In view of the frequency with which these disorders present in ordinary clinical life, the competence to diagnose and treat substance abuse needs to be exercised on a routine basis. A substance abuse history should be as much a part of information gathering as inquiries about allergies to penicillin are in internal medicine or symptoms of depression and anxiety are in a mental health workup. Unfortunately, it is the exception rather than the rule that mental health professionals seek competent substance abuse histories. In this lesson, information will be presented to enable the counselor to compile a competent substance abuse history and to develop a treatment plan based on such a history.

The Substance Abuse History

In my view, the essence of drug dependence, or drug abuse, lies in the relationship between the person and the drug. Physical dependence is of secondary importance to this basic psychological relationship, although it may, when present in severe degree, come to determine some of the variance. Listed below are what I regard as **a set of questions that, when answered, should provide a profile of the relationship and thereby indicate what elements are necessary for treatment planning.** Following each point, I have suggested a specific question.

I. Age of first use. **How old were you when you first used (specify intoxicant)?** The answer to this question will give some indication about the prognosis and severity of the problem. In general, **the higher the lifetime dose, the more problems one can expect.** Experience also suggests that those starting to use intoxicants such as alcohol and marijuana at age 10 will have more problems than those whose first use was at age 15. There is some rough prognostic utility to this measure.

II. Pattern of heaviest lifetime use. **When did you use (specify intoxicant) most heavily in your life?** Frequently this will tell you what clients have been doing with the drug. **For example, some clients only use drugs heavily enough to become dependent in the context of a marital or sexual relationship. Others will only use heavily when enmeshed in peer relationships.** For example, a high school senior may use heavily in the summer between high school and college while he or she is a member of a heavily drug-using peer subculture.

III. The recent pattern of use. **In the last two to three weeks, on the average, how many times a day did you use (specify intoxicant)? In this time what was the average dose in terms of dollars per day, milligrams, grams, etc.?** It is very important for decision making to know the dose and frequency of administration of the drug for the period of two to three weeks immediately preceding the interview. **If there has been no use of an intoxicant for two to three weeks, it is unlikely that serious withdrawal sequelae have to be considered.** Conversely, if intoxicants have been used heavily in this period, it is likely that at least some degree of physical and/or psychological dependence will be present.

IV. What drugs should be queried. Experience suggests that **asking about specific drugs yields the best histories.** For example, in some instances, as with the arylcyclohexylamines, which are phencyclidine and its derivatives, the user is probably getting a family of these drugs and not just the one PCP that users believe they are getting. PCP is made in "street" laboratories, often by chemists who are not well trained. What they produce is, therefore, frequently not pure. The following substances are the most frequently abused.

(a) **Alcohol:** It is important to remember that alcohol makes alcoholics. **The notion that the use of beer or wine precludes alcoholism, alcohol dependence, or alcohol withdrawal is untenable.** Therefore, it is important to inquire about use of alcohol in any form.

(b) **Nicotine,** in such forms as cigarettes, pipes, cigars: The Surgeon General's office has conducted research that suggests many clients in the United States want help in overcoming their nicotine dependence and will use information that is simply displayed on a professional's office coffee table. It is important to inquire routinely and to advise clients to seek treatment for nicotine dependence in addition to treating or referring for other drug problems.

(c) **Cannabis:** It is important to remember that **there are two forms of cannabis; one being marijuana or "pot"** and the other **hashish. The difference between these two forms is one of dose,** "pot" being between 2 to 10 mg. of THC per unit (a "joint") of use and "hashish" perhaps two to three times that amount.

(d) **Central nervous system depressants,** such as the barbiturates, benzodiazepines, methaqualone, glutethamide, and methaprylon. The slang term for this class of drugs is "downers."

(e) **Stimulants,** including amphetamines, cocaine, and sympathomimetics, as might be used in diet preparations. The mechanism of action of these drugs is very similar. Under blind conditions, for example, drug-sophisticated subjects could not discriminate amphetamines from cocaine. The slang term for this class is "uppers."

(f) **Tranquilizers, antidepressants, and over the counter (OTC) drugs: The sedative properties of these drugs define their abuse potential. These drugs are usually not used as primary drugs of abuse. Rather, they are used to enhance the intoxicating effects of primary drugs of abuse,** like "boosting the high" from heroin by using amitriptyline.

(g) **Inhalants,** such as glue, paint, aryl and butyl nitrates, nitrous oxide, gasoline, and industrial solvents. All these substances can be abused by those seeking intoxication. **In general, inhalants are used by very young populations, usually around the age of 12. As users mature, they tend to give up inhalants. It is unusual to encounter a person abusing inhalants for more than a few years. If one does run into such a case, the probability of neurological, renal, or cortical damage is very high and should be routinely tested.**

(h) **Arylcyclohexylamines:** These are phencyclidine (PCP) and its chemical relatives. Slang terms are "angel dust," "zoom," and "Sherman."

(i) **Opioids:** Heroin, morphine, methadone, meperidine, codeine, and their synthetic or natural derivatives have narcotic effects in human beings. They have many slang terms such as "horse" and "boy" for heroin.

(j) **Hallucinogens:** LSD, STP, and mescaline are some of the substances in this group.

V. Behavioral and emotional symptoms and drugs. **The next important point for inquiry is the relationship between psychopathological symptoms and drug use. For example, has a client experienced hallucinations or delusions only in association with use of hallucinogenic drugs or have hallucinations and delusions antedated the use of drugs?** Did he or she ever become paranoid or see or hear things that were not really there, without drugs being involved? It is important to know whether the person has a primary substance abuse disorder or a primary mental or emotional disorder complicated by a substance abuse disorder.

VI. Tolerance and/or withdrawal. Has it taken more of the drug to get "high" or to relieve withdrawal sickness? **The hallmark of withdrawal symptoms is tremulousness. One should question whether a client has increased the dose to achieve any desirable effect;** that is, has the client developed drug tolerance? **Young alcoholics may show a "telescoping" of tolerance; i.e., they become tolerant and dependent in a matter of months instead of taking years as is usually the case in their adult counterparts.**

VII. Preoccupation with the drug. Has the client noticed that drugs are important enough to put other important life issues out of his or her mind? **Drug-dependent persons regularly report that drug taking and/or drug seeking occupies a major portion of their mental energies, and it does so to the exclusion of family, friends, and work.** Clients usually recognize this preoccupation.

VIII. Loss of control. Has the individual become aware of his or her poor control over drugs regarding frequency of use or amount of use? **Drug-dependent persons usually report that their control over drug-taking is inconstant or non-existent.** They may use drugs more often than they intend; they may use more than they intend; or they may report both patterns of behavior.

IX. Using despite negative consequences. Has the client noticed that he or she uses it even though aware that it is destructive financially, personally, or health-wise? Drug-dependent persons regularly report that they are **conscious of using intoxicants despite known disadvantages,** such as family disagreements, loss of mental function, blackouts, cirrhosis of the liver, the subacute bacterial endocarditis seen in heroin addicts, and financial drain from expensive habits.

X. Attempts to cut down or stop. What methods have they used? Why do they seem to fail? What has worked for them in the past, even if only for a short while? **Most drug-dependent persons report frequent attempts to stop or cut down because they realize there are negative consequences.** Has the individual tried to stop or cut down because he or she knows it is detrimental?

XI. Is there a history of convulsions? Has the client ever had fits, convulsions, "falling out," or seizures? **A history of convulsions with adult onset should raise the possibility of substance abuse.** Moreover, if dependence on alcohol or depressants is present, a history of convulsions should lead the consultant to recommend hospitalization, all other factors being equal.

XII. What do they get from the drug? What are some of the feelings experienced when drinking, snorting, or shooting the drug? **It is sometimes important to point out to clients that, based on their own reports, they may have had no pleasure and in fact frequently have great displeasure and substantial real life problems from their involvement with drugs.** To assume that people use drugs regularly because they get pleasure is often incorrect. Clinical experience, corroborated by a growing body of research, suggests that **people who take potent amounts of psychoactive substances on a regular basis induce a basic state of dysphoria that is temporarily relieved by the administration of the drug.** Often, when reviewing with clients what they get from the drug, the dynamics of their relationship with the substance will become clearer, not only to the counselor but to the client as well.

XIII. Why are they coming for treatment at the present time? What has happened to make the individual seek treatment at this time? **Frequently drug abusers come to treatment because they have "bottomed out."** This can be loosely translated as **a major life crisis** precipitated sometimes by the decision of a spouse not to tolerate further drug taking; sometimes by occupational problems, as when the client's job is threatened; sometimes by legal pressures, as some forms of intoxicant use are illegal and occasion contact with the criminal justice system; or substantial health problems.

XIV. The confidentiality issue. It is important to remember that **opioids have unique legal requirements regarding confidentiality because there are stringent federal and state laws concerning who may or may not have access to the information an opioid abuser may divulge.** In general, **the client should be made aware that the counselor will not convey information divulged in the clinical encounter without written specific consent from the client. This will cover almost all probable occasions except those regarding medical emergencies, federal audits if the client's treatment is federally funded, and court orders that a mental health professional must follow. In some instances it may be necessary to consult a lawyer to ensure professional decisions regarding release of information will not lead to a lawsuit.** A counselor might say, "You should know that without your written consent, I might be fined and/or jailed if I tell anybody—your wife/husband, employer, or children—anything about you, including confirming that I've ever seen you. If a court tells me I must, then I will have to seek counsel about whether or not I can tell the court. If there is a medical emergency, I might have to tell to save your life. If your treatment is funded by federal money, auditors may have access to your records. Do you have any questions about this?"

XV. Vocabulary—a non-issue. Many health care professionals feel inadequate in responding to the needs of substance abusers because they do not know the slang of the drug world or perhaps the accompanying street slang. Clinical experience indicates that **drug abusers are seeking competent, concerned care. A lack of knowledge of street slang is, in most instances, a non-issue. If words are used that the counselor does not know, he or she should simply ask what the terms mean.** For example, in Chicago there are drug patterns called "T's and Blues," "Doors and Fours," and "Syrup and Beans." One can't keep up with all these even if one is a full-time specialist in drug abuse. I have never seen a client bothered because a counselor did not know the name of a particular drug or drug combination, or was unfamiliar with street slang. The basic issue is concern and competence; the knowledge or lack of knowledge of street slang or of terms for drug abuse is irrelevant. The counselor can say, "I don't know what 'T's and Blues' are. What drugs are they?"

XVI. Get to the point. The classical wisdom in the mental health field practice is that drug abusers may deny or exaggerate their intake and that alcoholics will deny the extent of their drinking. This appears to be a stereotype. **The presence of denial or exaggeration seems critically related to the client's perception of the potential role of the professional taking the history.** Experience with substance abusers, confirmed by research, suggests that **if clients see the professional as a helper—not a replacement for spouses or employers—they will usually give valid, reliable histories.** So don't beat around the bush. Firmly, kindly **come to the point with questions like these:** "Your mother and father say you are using marijuana. They are quite concerned. How do you see it?" "Your husband says you are taking 20 to 30 Valiums a day. What is happening?" "How many drinks a day have you been having?"

XVII. Crisis aspect of coming to treatment. Drug abusers are frequently in a crisis when they seek help. Thus, your first encounter with a substance abuser can have special significance because of this crisis aspect. An immediate goal of management is to **reverse the sense of demoralization** many substance abusers experience. Therefore, it is extremely important to **project an image of competence, confidence, and calmness.** Know the referral resources. Make sound decisions, and implement them skillfully.

Diagnosis

The DSM-III-R diagnosis of Substance Abuse Disorders requires that three categories be considered: first, the pattern of pathologic use; secondly, the nature and degree of impairment; and thirdly, a time dimension. While such a division into three elements is somewhat arbitrary, it is necessary. **For example, third-party payments insist mental health professionals diagnose in DSM-III terms.** If one follows the points just made about obtaining a good history, making a DSM-III diagnosis should present little difficulty. Since the Substance Abuse Disorders are a relatively new classification case, it should not be surprising if the categories are changed in subsequent editions.

The Treatment Plan

The following points should be considered when compiling a treatment plan for the substance abuser:

1. **Substance abuse disorders are independent problems.** From a pragmatic point of view, mental health professionals should adopt the position that opioid dependence and alcohol dependence are unique and independent disorders. They are not simply expressions of neurotic conflicts or social pathology, although they may be worse when aggravated by neurotic conflicts or social pathology. This is a very important point. Many clients will defend themselves by stating that they cannot stop taking chemicals until their neurosis or their marital problems are resolved. **Counselors should insist that the primary, initial objective of treatment is the immediate and complete cessation of the use of chemicals for intoxication.** Furthermore, they should convey to clients that substance abuse is an independent disorder that needs treatment in its own right.

2. **The necessity of a program. Substance abuse disorders require a program that consists of a set of elements, many of which are not present in an ordinary counseling relationship and/or a usual medical treatment.** Substance abuse disorders cannot be treated solely with office psychotherapy.

3. **The program needs to be long term.** There is evidence that **when people become abstinent, the effects of substance abuse persist in their bodies for many months, if not years.** In addition to the biology of these disorders, substance abusers commonly develop a relationship with the abused substance that takes on many of the characteristics of a human object relationship. Mourning, particularly since the relationship is psychopathologic, can take a long time and will not be accomplished in any three-week withdrawal program.

4. **The key to the program is change. Hopefully, the history will have exposed the dynamic of the client's relationship with the intoxicant, and the path of action will be clear.** For example, a spouse wanting to become abstinent but in a marriage where the other spouse is constantly using intoxicants and will not stop using may require separation or divorce. If the client has been immersed in a drug-using subculture, he or she must become free of this social network if there is to be any chance of sustained sobriety. A change of residence or job may be in order. The requirement for change is real and usually the required changes are major.

5. **The treatment program requires monitoring. The use of breath analyzers and urinalysis tests for the presence of illicit drugs is a very important part of a modern substance abuse treatment plan.** Monitoring should be on a random basis, and urine samples should be taken under direct observation of a trained substance abuse worker. Breath analyzer tests are quick and inexpensive and these can be administered with an intoximeter.

Monitoring provides structure for the substance abuser. Many clients lack inner structure for control and are helped greatly by monitoring. It also frees the counselor from possible manipulative aspects, because the mental health professional will be able to recognize drug use activity. **However, it is best not to make definitive clinical decisions on the basis of one breath analysis or one urinalysis. Clinical decisions should be based on patterns.** It is also not uncommon for counselors to be aware of a return to drug use before the breath analyzer or urinalysis data confirm their suspicions.

6. **Rehabilitative treatment programs should involve the family.** The family should probably not be defined as part of the problem unless one consults skilled family workers who make such a determination following extended family evaluation. The notion that a heroin addict or an alcoholic can become drug free without the involvement of a spouse or significant other is a false one. However, it does require major life-style changes, and, if possible, **the family should be part of the network of care** and of the information system developed around each client.

7. **A rehabilitation treatment program requires formal assessment of the client's mental status. Substance abuse is frequently accompanied by other DSM-III diagnosable mental conditions, most notably depression and antisocial personality disorder. There is also evidence that phobias and perhaps minor mood disorders are overrepresented in addict populations as compared with community samples. These conditions may require independent psychological and psychopharmacological treatments.** There is no reason why such treatment cannot co-exist with whatever other therapy is necessary for the substance abuse disorder

The counselor should be aware that traditional alcoholism treatment philosophy, encompassed but not exclusively defined by Alcoholics Anonymous, opposes psychotherapy during the first phases of recovery. Some authors have written that psychotherapy is contraindicated in alcoholic populations for the first two years of their participation in AA. This may be true for some clients, but there are many others, such as those with diagnosable affective disorders, phobias, bulimia, or severe insomnia, who will require and benefit from independent psychotherapeutic care in addition to the substance abuse treatment program.

8. **Make use of community based programs.** In treating substance abusers, a referral to Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous, Pot Anonymous or—in the instance of family members—Alanon and Alateen, is an indispensable element in treatment. Clients with substance abuse disorders will gain a sense of affiliation and have a new social network free of pressure to use intoxicants. They will have examples of successful abstinence-free living as an ongoing part of their experience.

No mental health professional should ever miss the chance to refer a family or family member who comes into the office stating, "My husband drinks himself asleep every night and he is rarely available to me for conversation; our sexual life is almost nonexistent. It has been this way for years and he will not listen or go for help. Is there anything I can do?" Counselors should refer such clients to Alanon or, if the story centers on drugs of abuse other than alcohol, to Families Anonymous. These organizations are usually listed in the Yellow Pages in most communities in the United States.

9. **Recovering substance abusers can help.** In addition to AA, a counselor may be aware of recovering substance abusers in the community who can be of very real assistance in helping clients form social networks free of pressure to use intoxicants.

10. **Pharmacological measures.** A number of specific pharmacologic agents such as blocking agents for opioid dependence, narcotic substitution therapy with methadone, and disulfiram for alcoholics are other possible elements in the treatment package.

11. **Counseling or psychotherapy. There is controversy about the utility of psychotherapy in the initial stages of recovery.** Some eminent counseloricians consider psychotherapy contraindicated in alcoholics until they achieve one to two years of sobriety and are involved in AA. In my opinion, psychotherapy can add a valuable dimension not obtainable through contact with AA or NA. Ideally, as the counselor acquires more experience with substance abuse, he or she will be able to help the client maintain a relationship with AA or NA groups and modulate the need for counseling. Psychotherapy may not be applicable, appropriate, or effective with every substance abuser, but it should be tried.

12. **General health measures. A complete physical and medical history of each client should be obtained and appropriate treatment facilities located.** The use of potent amounts of psychoactive substances on a frequent or regular basis has negative biological and psychological consequences. I have reviewed the medical conditions commonly associated with various forms of substance abuse. (See the list of further reading at the end of this lesson.)

13. **Education concerning psychoactive drugs.** Education is a routine part of rehabilitative treatment plans with substance abusers. As a rule, clients will have counterculture beliefs or ideas about alcohol that are promoted by advertising, such as the notion that alcohol enhances social desirability and sexual functioning, promotes masculinity or femininity, and is associated with daring and with good times. **It is important that such belief systems be attacked** by providing educational data. Many younger persons with dependence on cannabis erroneously regard cannabis as a non-drug, something akin to a vitamin. The data concluding that cannabis

smoking may have pulmonary consequences similar to smoking nicotine cigarettes are important antidotes for such attitudes. Effective client materials may be ordered from the Addiction Research Foundation and from the National Institute on Drug Abuse. The information is inexpensive and effective. (See list at the end of this lesson.)

14. **Regular appointments with the counselor.** The clinical counselor can be an important beacon in a family's attempt to help a member manage a substance abuse problem. One can refer clients to a substance abuse program and still maintain quarterly, bimonthly, or perhaps monthly contact. As a service coordinator and case manager, the counselor can follow up medication treatment regimens, offer family counseling, and assist with appropriate referrals.

15. **If the client is physically dependent, hospitalization may be necessary,** particularly if the degree of dependence is moderate or severe. For example, someone using 20 to 30 barbiturate or methaqualone pills a day will not be detoxified successfully on an outpatient basis and will need hospitalization. Someone dependent on benzodiazepines in multiples of therapeutic doses of two or more will probably require hospitalization for a safe detoxification. Opioid dependence is an exception. Opioid dependence can be treated in a hospital, but there is no threat to an addict's safety from slow outpatient detoxification.

16. **Put the client in charge of his or her substance abuse rehabilitation program.** The professional should essentially be a collaborator in the client's primary efforts toward recovery."

Further Reading

Gitlow SE, Peyser HS: *Alcoholism: A Practical Treatment Guide,* Grune and Stratton, New York, 1980.

Mendelson JH, Mello NK: *The Diagnosis and Treatment of Alcoholism,* McGraw-Hill, New York, 1979.

Senay EC: *Substance Abuse Disorders in Clinical Practice,* John Wright-PSG, Littleton, Mass., 1983.

Schuckit MA: *Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment,* Plenum, New York, 1979.

Sources of Client Education Materials

Addiction Research Foundation, 33 Russell Street, Toronto, Canada M5S 2S1.

National Institute on Drug Abuse, 5600 Fishers Lane, Rockville, MD 20857.

Questions Based on This Lesson

1. Which of the following statements is/are correct?

   A. The earlier in life substance abuse begins, and the higher the lifetime dose, the likelier the complications will be more serious.

   B. In assessing a client for substance abuse, one should never ask about specific drugs.

   C. Knowing the context within which a client is more likely to abuse drugs is of little value in planning treatment.

   D. The distinction between hallucinations or delusions experienced in the context of drug abuse and such symptoms predating drug use has no clinical value.

2. Which of the following statements is/are correct?

   A. The hallmark of withdrawal symptoms is delirium.

   B. Drug-dependent persons usually report their control over drug taking is constant and strong.

   C. Most drug-dependent persons report frequent attempts to stop or cut down because they are aware of the negative consequence.

   D. A history of convulsions rules out the possibility of a substance abuse diagnosis.

3. In substance abuse rehabilitation, which of the following statements is correct?

   A. It is sometimes prudent for the counselor to consult an attorney before releasing client information.

   B. The counselor should be familiar with and be able to knowledgeably use street language.

   C. Denial on the client's part is worsened if he or she sees the counselor as someone trying to help.

   D. The counselor should always project a casual image and avoid confrontations.

over, please...

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4. In substance abuse rehabilitation, which of the following statements is correct?

   A. Individual psychotherapy is superior to any planned substance abuse treatment program.

   B. Short-term programs are much more effective than long-term ones.

   C. Monitoring the use of abused substances during treatment contributes to patient paranoia and should never be done.

   D. Substance abuse should be regarded as an independent problem, but other concurrent psychopathologic conditions should be appropriately treated as well.

Directions in Mental Health Counseling

VOLUME 1 • LESSON 2

Child Abuse, Sexual Abuse, and Neglect

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Directions in Mental Health Counseling
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EDITOR'S NOTE

Child abuse, including sexual molestation, is a disturbingly widespread phenomenon. Counselors engaged in treating children or working within educational or legal arenas are more likely to encounter the problem than many in practice. But all counselors should be alert to the possibility of such abuse since the effects on children are often devastating. Furthermore, the law requires that child abuse be reported, and professionals should acquaint themselves with the statutes of their own particular state.

In adult practice, most of us will be faced at one time or another with clients who were abused as children. Understanding the impact of such experiences on the client's development will facilitate resolution of the residual scars such clients bear.

Introduction

Changes in the mores of child-abuse reporting have expanded recognition of this serious problem and have catalyzed proliferation of scholarly and lay literature and such major databases as that maintained by the National Center on Child Abuse and Neglect (NCCAN), which consists of files on documents, research programs, and audiovisual centers. Data from child protective agencies nationwide documented more than **one million reported abuse cases in 1983 and an increase in reporting of 19% over the next two years.** Moreover, most people in the field agree that the **problem is significantly underreported.**

Using a sample of about 400,000 children, the American Association for Protecting Children found the following proportions of maltreatment: **major physical injury, 3.2%; other physical injury, 32.7%; sexual maltreatment, 8.5%; emotional maltreatment, 10.1%; neglect, 58.4%; and other, including abandonment, 8.3%.** Some children experience more than one form of abuse. **Studies based on emergency room visits show two thirds of children who come for treatment are less than six years of age, and about 60% are less than two years old. Adolescence constitutes a second peak of frequency in parental violence.** Most studies find no difference in the incidence of abuse of males and females, but that varies with the ages of the children in the study. **Very young boys may be abused more frequently than young girls, but adolescent girls are probably abused more than adolescent boys.**

Child abuse may occur in all socioeconomic groups and all subcultures, but **child abuse and neglect occur more often in compromised, socially and psychologically damaging neighborhoods and are associated with high life-stress factors.** Abused children tend to be part of families with higher child-to-parent ratios, either **larger families or single-parent families.** Ethnic differences indicate that abuse rates are **higher in nonwhite families,** but that is probably related to the confounding factors of poverty, divergent childrearing practices, and discriminatory attitudes among law-enforcement officials and professionals in reporting practices. Recidivism for child abuse is estimated at 50-60%; **Kempe** (1975) **estimated that a battered child is at 20-50% risk of permanent injury or death if returned home with no intervention.**

Clinical Features

Recognition and Diagnosis:

Abuse is blatant when the child presents with fractures, burns, bruises, or unusual injuries explained by implausible stories. **Documentation with radiologic, photographic, and standardized clinical examinations is still required.** Other cases, especially emotional abuse, are more subtle and difficult to detect.

Because self-reporting of child abuse is infrequent, persons other than the parent of the child are legally mandated to report cases. Most children are too young or too frightened to report being abused, and parents are reluctant to admit their actions because of guilt and fear of reprisals. "Doctor shopping" and seeking care in more than one medical setting are characteristic and make detection by the medical community difficult. Therefore, all adults who are in contact with children should be alert to the signs, symptoms, and indicators of abuse and should report cases, whether actual or suspect.

Indicators of Abuse:

Signs of abuse can be found in the parents and the child. **Abusive parents are often mistrustful, have a poor self-image, and are immature. They commonly have low frustration tolerance, poor impulse control, and either excessive hostility or apathy. They may be burdened by poverty, borderline**

intelligence, and/or substance abuse. They are often isolated from their own family and from others in their community. Psychotic or psychopathic behavior may be manifest. They themselves often have a history of being abused or neglected as children.

Abusive parents may feel love for their children but exhibit a lack of concern, knowledge, or understanding about their child's medical, developmental, and psychological needs. They may seldom look at or touch their child, have unrealistically high expectations of the child at the same time they are excessively critical, and express belief in harsh punishments to keep the child from becoming spoiled. They may oppose the child's participating in activities outside the home. In their interactions with professionals, they may be inconsistent and difficult to locate.

The abused or neglected child may be tardy or often absent from school for extended periods of time. Alternately, the child may arrive early or linger after school. **He or she may seem to fear home and parents or be withdrawn, passive, have low self-esteem, and be uncommunicative, overcompliant, inattentive, self-absorbed, or unusually tired.** Fearfulness, defiance, changeable behavior or misbehavior, and difficulty relating to other children and adults may alternate with a hunger for affection that is tempered with little expectation of being comforted when hurt or upset.

Clinical Characteristics

The Children:

Abused children have an increased incidence of premature birth, congenital abnormalities, or low birth weight, and they frequently experience lapses of child care such as missed immunizations, erratic treatment of illness, and poor hygiene. **A physical examination may show scars, bruises, or burns** with new lesions atop older ones. X-rays may show repeated fractures that are in varying stages of healing. Neurologic sequelae are important: Caffey described chronic subdural hematomas that result from violent shaking of the infant's head. IQ and cognitive studies show **lower school success and language delays,** both causes and effects of abuse and neglect. One review of records of children in an institution for the mentally retarded indicated that in 3-11% of cases, retardation resulted from injuries caused by abuse.

Typically, abused children have experienced dyssynchronous, nonempathic early care, either because of constitutional factors in the child, inadequacies in the parent, or both. That early experience begets symptoms that perpetuate the child's problems. **In studies of structured play settings, mistreated preschoolers demonstrate social and affective withdrawal,** which could be a reflection of having been rebuffed; **lack the pleasure so important in caregiver-infant bonding; are inconsistent and unpredictable; show shallowness or fickleness;** and are ambivalent and ambiguous in affective expression or negative affective communications. Friendly invitations from a caregiver or another child put abused children in an intense approach-avoidance conflict. Such children approach teachers only half as often as nonabused peers and tend to approach indirectly, by angling toward, backstepping, or coming near from the adult's side. Their attachments have an anxious quality. **Aggression develops more frequently in abused children, especially if they are boys or are young when abused.**

The abused child may have certain characteristics that draw abuse upon him or her. The child may have **special significance for the parent, physically resemble a dislike family member, be developmentally delayed or handicapped,** or have **a chronic medical problem.** Children with early medical complications, or who for some other reason have been separated from the parents so that bonding failed to occur properly, may be especially vulnerable to child abuse. The chronically ill child poses great demands on the parent and may be a constant reminder of the parent's sense of inadequacy and failure. "Von Munchausen by proxy," a peculiar variant of child abuse that has received attention in the literature, is diagnosed when a parent creates physical symptoms in the child, such as putting blood in the child's urine, that result in the child's undergoing sometimes-painful diagnostic procedures.

The abused child learns to think of himself as bad, worthless, and deserving abuse. Frequently such children are difficult to like, defiant, or oppositional, and they have behavior problems that contribute to the abuse cycle. Those characteristics may carry over into the child's contacts with peers, teachers, relatives, and others so the child engenders negative feelings in other settings. Some children learn that their expected role in the family is to be bad, and they oblige by being bad and getting punished as a way of relieving tensions between other family members.

The Families:

Stress factors, such as too many children, poverty and unemployment, substance abuse, family discord, or difficult temperament in the particular child, may contribute to one child being selected as a target of abuse. **Several studies of abusing parents find that they are nonempathic, impassive, or abrupt in their interactions with their children,** even though they engage in many activities directed toward the child. **Parental response to the child is inconsistent,** and inability to adjust to the child's developmental level is very common. Frequently abused themselves as children, the parents may have been expected to perform physical and emotional tasks beyond their years and to take care of and nurture their own parents. In return, they may have received rejection and criticism but little nurturing. Childhoods centered on attempts to please parents produced

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intense fear of rejection and criticism and an unstable sense of identity. Such children become adults and parents with fragile trust, low self-esteem, poor frustration tolerance, and an expectation that others would fail them. They may have disengaged themselves from their parents, their spouses, and helpful persons in their community. Unable to provide their children with care and nurturing, **they repeat the same pattern they experienced themselves. Their child's crying, mischievousness, or other behaviors are perceived to be personal attacks or intolerable reproaches** by the parent whose emotional immaturity and frustration intolerance makes them vulnerable to sliding from normal anger to a rage in which they lose control over their behavior toward their own child.

Other characteristics of abusive parents are role reversal, self-righteousness, and ambivalence. As their parents did with them, **abusive parents may expect their child to take care of them and may see their child as there to meet their own needs or as an object of their harsh criticism. Often, abusive parents feel that the child is their property,** thus justifying their beating the child to teach him or her a lesson when he or she cries or becomes demanding or disobedient. **Ambivalence** results from the abusive parents' love of their children conflicting with their own unmet needs, rage, and frustration. When they are overwhelmed, they strike out at the child. That **explains the intermittent nature of most abuse, the strong parent-child bond, and the severe disturbance caused when someone attempts to disrupt that bond.** With a strong need to succeed as a parent, the vulnerable parent recognizes having a child removed from their care signifies failure. Although ambivalent about intervention and often violently protesting it, parents are frequently relieved when an intervention is made, all the while blaming the child welfare agencies and expressing suspicion and plausible feelings, sometimes accurate, of having been victimized.

Intervention and Treatment

No amount of understanding of familial and social causes of child abuse reduces the need for intervention and treatment for the abused child. Intervention for child abuse frequently requires several disciplines: medicine, social services, legal services, child advocacy, and mental health, ideally organized as a well-coordinated treatment team with six goals. **Protection of the child is the first priority.** It requires acute intervention, including acute medical and surgical care, and immediate institution of measures to deal with acute sequelae of physical abuse. **Reporting with adequate documentation is mandatory.** Rapid assessment of the child's and family's environment, and diagnostic evaluation of the child and family are necessary before any dispositional arrangement or sensible treatment program can be developed.

The first treatment principle is an emphasis on keeping the child in the home or returning the child to the home as soon as possible. If neither of those is realistic, the child should be placed in a permanent, stable family situation as soon as possible. Long-term, comprehensive intervention is usually necessary and may require strong professional advocacy, as the acute needs of many new cases could deflect resources from children currently in treatment. Lastly, **ongoing evaluation of the efficacy of the intervention** should be part of the program.

Secondary prevention is possible even though intervention occurs late in the cycle of abuse. Among the obstacles to prevention are the child's behavior problems that may have developed as a result of the abuse and the parents' inability to change their parenting patterns and their alienation from the social service system. **The child and the parents should have different counselors** so the child has an ally and the counselor does not have difficulty with countertransference. The parents' excessive needs may jeopardize the child's treatment if they effectively compete for the counselor with their child or feel criticized when the counselor is sympathetic to the child.

Meeting the needs of abusive parents is taxing and difficult. It requires outreach and other treatment extensions and a persistent treatment alliance even when the parents reject, run away, or reproach the counselor. It requires a consistent, warm, nonjudgmental attitude. **It may require home visits, extensive interagency coordination, responsiveness to crises, and toleration of parental dependence on the counselor.** Once that dependent and nurturing relationship is established, the counselor can allow the parents to experience being cared for and gradually to become independent and assume increasing responsibility for their own lives. The first stage is arduous and may require months or years. The feelings of the counselor and team members in response to the parents' behavior may be difficult to tolerate, and it requires much restraint and self-understanding not to act out those feelings with the parents or with the child. To do that, the counselor must be able to confront the parents' actions without experiencing them personally. A person or group that can provide support, ventilation, and resolution of these feelings is extremely useful.

Following the team-treatment phase, **the second phase allows the parent to assume more independence, which is also a slow process.** The counselor must encourage, but not demand, growth and must guard against the parents' becoming overly dependent. The parents' gains are precarious and easily eroded by situational setbacks that may cause them to revert to low self-esteem, dependence, and impulsiveness. Those lapses must be accepted nonjudgmentally. If they can be overcome, the parents will continue to make steady progress. A consistent counselor is important throughout this process. **The ideal is to share case**

management with at least one other professional, thus allowing the parents to have someone available at all times and to allow the counselor relief and support. That approach also helps the parents learn that more than one person can be trusted.

Team difficulties frequently develop when a number of professionals and paraprofessionals from different fields attempt to work together. They include poor communications; territoriality, as each professional emphasizes his or her own diagnosis, treatment, or theory; and professional jealousies. Some professionals are overworked and they may also be undertrained, which adds to the inherent frustration. The chronicity and severity of the problems may demoralize team members, particularly in a mental health care epoch marked by lack of resources. A team leader with good organizational skills who can encourage mutual respect and cooperation in providing comprehensive services for children and families can avert much strain. When functioning well, the team can offer mutual support to its members by sharing feelings and frustrations.

Most parents can be helped by the treatment process described above, although they may not be cured or become model parents. They may be able to assume effective and appropriate care for their children and experience more fulfillment in their lives. The intervention should be conducted by carefully screened, sensitive individuals who have had good parenting themselves, who are specially trained and who are supervised, but the primary counselor need not always be an expensive, highly educated professional.

Legal Aspects

All states now have mandatory reporting laws for child abuse under the civil code. These laws vary from one jurisdiction to another and are frequently revised. Professionals should be acquainted with the statutes

of their own state or obtain information from advocacy groups such as the state attorney general's office and local courts. Each state has an age limit below which reporting is required, usually between 16 and 18 years. Reporting criteria range from mere suspicion of abuse or neglect to having "just cause" to believe physical abuse has occurred. Some states consider neglect and abuse together and others differentiate them. Some states require anyone to report, whereas others require only physicians or other professionals who are notified by a physician to report. All states grant the reporting person immunity against criminal or civil action, and many state statutes contain a penalty clause for failure to report abuse.

Most state statutes designate a particular agency to be the recipient of reports and provide specifics regarding the substantiation of abuse and follow-up. That is usually mandated within a specific time period. All states have criminal prosecution statutes for physical abuse, which is considered assault. Those statutes are used less often as states focus on providing services to abused children and their families. If necessary, legal actions are taken through the civil route.

Most states waive confidentiality provisions so that physicians, counselors, and others can be required to divulge information in the course of reporting and investigation. Most states have procedures for interviewing the child, for ascertaining the safety of siblings, and for emergency detention with or without parental consent. All states require the parents be given a Miranda warning before they are interviewed if criminal prosecution is imminent, and some states grant children and parents the right to counsel.

Custody Decisions:

The prevailing philosophy of treatment advocates custody and placement of the child in his or her own home when possible and engaging parents in a voluntary treatment program even after abuse is confirmed. However, no child welfare agency in any state is equipped to provide all its cases with ideal treatment. A lack of resources and a lack of appropriate knowledge may result in custody or placement of the child outside a potentially salvageable home, thus creating additional stress that may be heightened by punitive attitudes on the part of social service or legal professionals.

If possible, avoiding court is best, as it is frequently a destructive experience. During court proceedings, people who have been or will be working with the parents are required to give evidence against them. Judges and juries must consider the child versus the parent and may decide in the child's interest, which is against the parents' will and which alienates them and makes them feel betrayed by many parts of the support system. A proper investigation and gathering of evidence may subject the parents and their helpers to a grueling exposure of their conduct, psychopathology, and history. That process, painful to the parent, negatively influences those who may need to work with them.

If the parents' refusal to cooperate with treatment places the child's health or life in danger, the case must be taken to court. The court may then decide on custody after considering social service information. **Options include placement and custody in the original home with state supervision, custody with the state and placement with a foster family, or termination of parental rights with permanent adoption. The expert witness is crucial to a court case.**

Experts' reports must contain organized and factual information and opinions; recommendations should be stated concisely and be based on facts about the case as well as known concepts in child development.

Sexual Abuse

Incidence, Prevalence, and Problems of Reporting:

An estimated 12 million children are sexually abused each year in the United States. The prevalence of persons who report both contact and non-contact abuse ranges from 19% to more than 50%, depending on the methodology of the study and the definitions of abuse and sexual abuse. **One third of victims are children six years of age or under. Preschoolers are more likely to be molested by a family member, and females are victimized two to four times more often than males.** A random survey of 2627 adults selected from the Los Angeles telephone book found that 27% of females and 16% of males reported they had been sexually abused as children, but only 3% reported this abuse to an authority. Seventy percent of those who reported the incident said that reporting had no effect. **The rate of repeated offenses among treated adult sexual abusers is 75% to 80%.** Reporting increased by 59% between 1983 and 1984, according to the Child Welfare League of America. However, not all cases are reported, and of those reported, only 42% are substantiated according to American Humane Society statistics for 1984. The many reasons for failure to report include fear, denial, and belief that changes will not occur after reporting. Delayed reporting occurs as a result of those factors and because of the victim responses described below. **Underreporting undoubtedly occurs. Intimidation of the victim is a routine concomitant of child sexual abuse and the child may disclose the molestation only after a long period of time.** It is also known that **overreporting may occur in the context of disputed custody, because the**

allegation of sexual victimization is one way to obstruct a child's placement in the care of the accused adult.

Clinical Aspects

Physical Features:

The physical manifestations of sexual molestation are usually soft-tissue injuries, such as bruises and lacerations, which may heal rapidly. Unless the victim can be examined promptly or unless sophisticated methods can be used to verify previous injury, the testimony of the victim is the only documentation. New pediatric approaches include standardized protocols and examination using magnification with a colposcope for physical signs of microtrauma. Photographs may be taken to collect medical and legal evidence for permanent documentation. In one study the occurrence of lesions in sexually molested girls was compared with that in asymptomatic girls and girls being seen for other genitourinary complaints such as vaginitis or dysuria. **Genital trauma, such as scars, attenuation of the hymen, synechiae, or friability, was significantly increased in sexually abused girls** as compared with asymptomatic girls. **Many such findings occurred in girls with other genital complaints,** however, suggesting either that vulval inflammation might lead to some of those symptoms or that those girls had been molested as well.

Psychosocial Aspects:

Presenting emotional and behavioral symptoms include some features that may occur in victims of any age and others that are relatively specific to the developmental age of the child. The act of being sexually abused can precipitate both pseudomaturity and regression. Clinical versatility can differentiate psychological evidence of sexual abuse in a youngster's behavior from the background noise of the typical traumas of life and developmental thrusts.

General and nonspecific symptoms that may occur in preschoolers, school-age children, and adolescents **include anxiety, guilt, phobias, withdrawal, disturbances of appetite and sleep, somatic complaints and conversion hysteria, and eroticization, the appearance of sexualized behaviors. Preschool children may be more likely to react with renewed aggression, hyperactivity, lying, separation fears, and signs of impaired trust. Older children and adolescents may develop school problems, run away, engage in delinquent or acting-out behaviors, abuse drugs, become depressed and attempt suicide, or display tics, borderline states, aggression, or even obsessions and psychosis.**

The seriousness of psychological effects is not well-correlated with the severity of the abuse. Not only is there a continuum of abuse but also the resilience of the victims and the personal or family support available to them may vary. Many studies have reported on groups of molested children and adolescents and have sought to find a pattern based on the relationship of the perpetrator and victim. **It appears that a single incident of molestation by an unrelated person is less psychologically damaging than ongoing incest with a trusted adult. The most common patterns are incest between fathers or stepfathers and daughters, followed by other adult male family members with girls, followed by brothers. Incest between adult women and their young male relatives is quite uncommon** and appears to be associated with much more severe psychopathology in the perpetrator.

For the victim, the abuse that is experienced may be more than sexual, depending upon the emotional context in which it occurs. That is especially true in the case of incest. **Part of what the victim experiences depends upon**

the aggressor's motive. For the older person who abuses a child, it may be a drama of overpowering or manipulating a vulnerable person, a reenactment of a childhood trauma of the perpetrator in an intimate context with a specially chosen victim, or a combination of either of those two motives with real affection. **In cases where the abuse is incestuous, the impact is tremendous.** At the level of the child's individual relationship with the molester, the victim endures the **betrayal** of a child's right to be cared for by adults. Studies have shown that, at the family level, roles are often distorted, and that **sexual molestation of children seems likelier to occur in families that are isolated, in which the marital relationship is troubled, and where communication is closed, subterranean, or bizarre.** A child in such dysfunctional families not only lives under the emotional fallout of sexual abuse but also faces the problem of experiencing **trauma in a interpersonal milieu with impaired communication that hampers opportunities for corrective experiences.** Such factors compound the trauma, contribute to a cumulative insult, and confound the counselor's understanding of the extent to which molestation alone contributes to the child's symptoms. **Further complicating the situation are the emotional, social, and economic consequences of civil and criminal proceedings that may occur if the child discloses the abuse.**

Diagnostic Approaches:

Clearly, no simple psychosocial patterns are apparent, and therefore no one formula for such evaluation suffices. Proof of sexual molestation can best be obtained by a careful physical and pelvic examination using colposcopy and documentation with photographs. **Psychological evaluation has been sought to provide post hoc documentation in cases where the physical examination has been omitted or where findings are equivocal. However, important functions of such an evaluation are assessment of the emotional damage wrought by the molestation and treatment planning.**

Much has been written about how to interview the child, the use of anatomically correct dolls, clinical videotaping to document the often-eloquent nonverbal communication of a very young child, and family involvement in the diagnostic exploration. For the reasons described in the previous paragraph, it is necessary to **tailor the evaluation of the child and family to the individual case.** Psychopathologic sequelae of sexual molestation may be protean and severe. For example, in a population of hospitalized latency-aged children on an inpatient psychiatric unit, Livingstone (1987) found **sexually molested children had greater frequencies of psychotic symptoms, major depressive disorders, and somatic complaints in comparison to physically abused children, who tended to manifest conduct disorders.**

The victimized child's coping responses and defenses are vigorously mobilized and have their own effect on later learning and experience. Improved clinical recognition will strengthen expert testimony and assist in treatment planning. For example, Summit (1983) has described a characteristic **Child Sexual Abuse Accommodation Syndrome: (1) secrecy, (2) helplessness, (3) entrapment and accommodation, (4) delayed, unconvincing disclosure, and (5) retraction.**

Certain diagnostic features may be specific to sexual victimization. The National Summit Conference on Diagnosing Child Abuse, held in October, 1985, proposed a category of "Sexually Abused Child Disorders" be included in DSM-III-R. The category, Sexual Disorders of Childhood, would encompass the eroticized child and a "post-traumatic stress disorder" with specific categories for children. The conferees believed many sexually abused children fit the latter category, so counselors could use Axis III to indicate sexual abuse.

Legal Considerations

The Child as a Witness:

During the 1970s, professional opinion moved away from recommended therapeutic approaches to deviant behavior to a "get tough" punitive response, with increased emphasis on prosecution. As a deterrent, many state legislatures enacted mandatory reporting laws and recommended harsher penalties for abuse. An unfortunate consequence of the increased reliance on litigation was a greater demand for testimony by the victimized child. That often imposed further stress upon the child. Indeed, the psychological harm resulting from participation in adversarial proceedings has been termed a "second victimization."

Our criminal code permits the accused to confront the accuser, but when the accuser is a small child who is frightened of the court and of the molester, the confrontation can be very painful for the child. Putting the child on the stand forces weighing retraumatization by inquiry against the perpetrator's evading punishment, thus leaving the child to feel no retribution is possible. Moreover, the child's poise may dissolve on cross-examination, and he or she may be unable to convince the court of the truth of his or her testimony. Goodman's (1984a-c) **research on children's testimony indicates testimony given by a child is less likely to be believed by juries than the same testimony given by an adult.** Nonetheless, Claman (1986) has asserted **testifying need not be traumatic for the child if it is properly handled.** For some youngsters, testifying enables them to actively transcend the role of the victim and gain more control.

Extensive discussion has been devoted to the question of whether the child does or does not lie in court. No absolute answers exist. **Each child must be carefully evaluated for his or her perception of the question, of the** event, and of the consequences of what is said. Children are slower to understand questions and generate answers. A young child may appear to lack consistency in reporting or to be fusing or confusing the facts. If the child's family has failed to teach wrong from right, such knowledge cannot be assumed in the child witness. A child may not know the meanings of terms such as molest, abuse, penis, vagina, or anus. Children imitate, and they are suggestible and compliant with parents and adults whom they seek to please or protect. Children may not understand or be informed of the consequences of their statements or acts. For any witness, the memory of complex events is subject to error on recall, and emotional flooding may increase misperception. The child's sense of time may be immature, so a developmental assessment should affect the listener's interpretation. For example, usually a five-year-old is unaware of the calendar date. A child who gives exact dates on the stand may have been coached. The investigational procedure itself is a powerful experience for the child, and the memory of an actual event may be contaminated by memories of intervening descriptions of the event. When an adult with whom the child has shared the story testifies for the child, it is considered hearsay evidence: such testimony can be given in some jurisdictions without the accused having the right to challenge its accuracy.

The Role of the Expert Witness:

The role of the child psychiatrist, psychologist, counselor, or pediatrician may be **to evaluate whether the child should testify, to more thoroughly evaluate the family with regard to possible false allegations, to prepare the child to testify, and to debrief the child afterward. Depending on whether the case is being heard in civil or criminal court, the expert witness may be asked to address the question of damage to the child, to field hypothetical questions concerning the dynamics of child sexual abuse and ensuing psychopathology, or to testify on what constitutes an adequate evaluation of**

child sexual abuse. Other roles include assisting attorneys in examining a child and even consulting with defense attorneys. **The approach to gathering information and managing confidentiality in the consulting room is very different from that in the adversarial legal system, and it behooves the expert to clarify those roles explicitly.** The case report and testimony should contain organized factual information. Opinions and recommendations should be stated concisely and should be based on facts about the case as well as established concepts of child development.

In cases that concern the granting of sole custody of a child to one of the parents, experts must attempt careful screening to protect the child from abuse and the parent from wrongful accusations. In reviewing incest accusations from custody cases that were referred to a forensic or specialist child psychiatrist, Benedek and Schetky (1986) were unable to substantiate 55% of allegations. In contrast, Green (1986) found only 36% of accusations false. That points up the importance of distinguishing between allegations that are false and those that are unsubstantiated. One must also remember only the most vexing and ambiguous cases get referred to forensic or child specialists, creating a potentially biased sample.

Sexual Abuse Treatment

Primary Prevention:

Increased awareness of child sexual abuse has sparked debate about the openness of sexual information in schools and has led to well-designed films and community educational campaigns to teach children about "OK touching and Not-OK touching," the (bad) "Oh-Oh feeling," and that the child can "Say No!" Although early post-test findings suggest that, unfortunately, **these**

programs may have a very limited impact and may not equip the child to make crucial social discriminations about potential abusers, **they may have the indirect effect of sensitizing adults who care for children to the signs of strain that children may evince when they are threatened or abused.**

Secondary Prevention:

Although a thorough diagnostic evaluation of the child is required by law, **acute intervention by the counselor can have a powerful effect. That means situational intervention, including accompanying the child to court as well as talking about the molestation in the counselor's office.** Unquestionably, the counselor who sustains a supportive relationship with the child through the disclosure crisis and the often-prolonged familial and legal repercussions can provide a beneficial effect. In psychotherapy, the child can be helped greatly by having a private space to talk and play out his or her experiences and attain some mastery of them. **Involvement of the child's counselor in the civil or criminal proceedings complicates the therapeutic relationship,** as the counselor may be impelled into a more-investigational approach to the child and unwillingly become yet another adult who invades the child's personal space. **Multimodality approaches including family therapy are often necessary.** The counselor should expect any molestation case to evolve from crisis through accommodation and slow resolution. Later working-through must occur when the child has to navigate the next developmental phases, particularly the tasks of approaching intimate relationships in adolescence. The chronicity and severity of the sequelae of sexual victimization mean **adequate treatment is long and costly,** a fact that is discouraging for patients and for health care workers in an epoch of decreasing availability of mental health care reimbursement.

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QUESTIONS BASED ON THIS LESSON

5. Which of the following statements is correct?

   A. Only 4% of child abuse incidents involve sexual molestation

   B. It is estimated that a battered child is at 20-50% risk of permanent injury or death if returned home without intervention

   C. Health professionals cannot report child abuse cases if such revelation violates the rules of confidentiality

   D. Most child abuse incidents are accidental, the result of brief emotional outbursts on the part of otherwise quite stable parents

6. Which of the following clues may suggest the existence of child abuse?

   A. Absences from school for prolonged time periods

   B. Withdrawal, passivity, and low self-esteem

   C. Fear of home and parents

   D. All of the above

7. Among the features of abused children that may particularly draw abuse on them from parents are:

   A. Adopted status

   B. Only-child status

   C. Physical resemblance to a disliked family member

   D. Unusually good physical health

over please...

8. Which of the following statements is correct?

   A. The experience of sexual abuse can set the stage for later sexual difficulties, but rarely has an impact on personality development

   B. The least traumatic form of sexual abuse is ongoing incest with a trusted adult

   C. Child sexual abuse is more common in families where closeness, a good parental relationship, integration within the community, and good communictions exist

   D. Sexually molested children appear to have greater frequencies of psychotic symptoms, major depressive disorders, and somatic complaints as compared with physically but not sexually abused children

Directions in Mental Health Counseling

VOLUME 1 • LESSON 3

Obsessive-Compulsive Disorder: New Findings

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Directions in Mental Health Counseling

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EDITOR'S NOTE

With recent advances in genetics, neuropharmacology, and neuropsychology have come new findings about the etiology and treatment of obsessive-compulsive disorder (OCD). During the past 300 years, varied causal explanations for this psychiatric disorder have been presented, with current findings reflecting a neurobiological basis. Etiological studies have, in turn, prompted refinement of treatment modalities. A multi-modal approach, incorporating behavioral techniques and pharmacologic approaches, has gained favor in the treatment of patients with OCD.

OCD is essentially an anxiety disorder that carries the basic features of ego-dystonic obsessive thoughts and compulsive behaviors that the individual feels compelled to perform. Although they recognize what they are experiencing is inappropriate, people with OCD nonetheless seem unable to control their distressing thoughts or behaviors.

OCD shares many features of affective illness. Major depressive episodes occur in at least 50% of OCD patients. In contrast with affective illness, however, OCD tends to be more chronic, shows a younger age of onset, and has a lower female-to-male incidence ratio. Similar to phobic disorders, OCD is usually characterized by avoidant behavior. For the OCD patient, however, avoidance usually does not prevent anxiety. Unlike individuals who suffer with major psychotic syndromes, OCD patients possess insight into their condition.

Four syndromes are particularly common among persons with OCD. 1) About 50% manifest obsessions with dirt, contamination, germs, and bugs. They engage in compulsive washing. 2) The pure obsessional, representing about 25% of OCD patients, describes repetitive, intrusive, reprehensible thoughts, usually of a sexual or aggressive nature. 3) Pathologic doubt, accompanied by compulsive checking, is common. 4) In a rare form of the disorder, called primary obsessional slowness, extreme slowness is the predominant symptom.

In reviewing treatment approaches, Dr. Insel notes that nondirective psychotherapy has been largely unsuccessful in reducing symptoms of OCD. Recent neuropsychologic studies using imaging techniques appear promising. These findings suggest that frontal-striatal pathways in OCD may be an important treatment focus. Behavioral therapy, using in vivo exposure and response prevention, has been successful with 80% of OCD patients. However, this therapy may be inappropriate for some individuals. Pharmacologic treatment may also prove useful. Clomipramine (Anafranil), a potent blocker of the neuronal reuptake of serotonin, has been shown to be beneficial in such cases, and fluoxetine (Prozac), which has a similar biological influence although not specifically approved by the FDA for OCD, may also prove to be helpful.

Introduction

Obsessions and compulsions are present in a variety of psychopathologic conditions including mood disorders, schizophrenia, anorexia nervosa, and Tourette's syndrome, as well as in otherwise normally functioning individuals. A unique syndrome in which obsessions or compulsions are the primary symptoms and the major source of disability has been recognized for more than 300 years. **That condition, which we now call obsessive-compulsive disorder (OCD), was previously known as scruples, religious melancholy, or obsessional neurosis.** Although it has changed very little over the centuries, explanations for its cause have ranged from religious to psychosexual, in keeping with prevailing theories. Nowadays, advances in genetics, neuropharmacology, and neuropsychology have increasingly dominated our search for the etiology of various illnesses, and accordingly, new findings in OCD reflect a neurobiological basis. The usefulness of that approach may ultimately depend less on determining an etiology and more on providing new therapies for this mysterious disorder.

Diagnosis

Obsessions are cognitive symptoms; compulsions are ritualistic behaviors. The most recent attempt to define criteria for the syndrome is shown in Table I (American Psychiatric Association, 1987).

The following points about the diagnosis of OCD deserve special emphasis. **Unlike individuals with obsessive-compulsive character disorder, persons with OCD complain of ego-dystonic symptoms** ("I know that it is stupid to be so concerned about trivial things, yet I have to check them again and again. It's like being on remote control."). **OCD patients tend to be seen as people with compulsive characters who have decompensated. Although the names are similar and the two diagnoses share several defense mechanisms** (e.g., **reaction for-**

mation, undoing, and displacement), many patients with OCD do not have compulsive characters (Rachman & Hodgson, 1980). Indeed, **those with OCD are more likely to manifest such premorbid traits as introversion and dependence rather than classic obsessionality.** Rapoport and her coworkers (1988) have followed children with OCD prospectively to determine the relationship of "trait" and "state" obsessionality. **Their data suggest that OCD children manifest few if any obsessional character traits prior to the onset of the disorder. Years later, after a long struggle with OCD, many of those children showed more of the rigidity, stubbornness, and emotional constriction usually associated with the obsessional character. Thus, these traits may be secondary to the disorder rather than etiologically linked to OCD.**

Unlike clients with major psychotic syndromes, those with OCD retain insight ("This thought about contamination is crazy, but I still have to wash my hands, and that's what bothers me so much."). That distinction, which may seem obvious in most clients, is integral to almost all definitions of the syndrome. Unfortunately, the presence of insight is equivocal for a substantial subgroup of clients who **have been labeled either obsessive-compulsive psychotics or schizo-obsessives and appear either more bizarre or more disabled than those with the classic "neurotic" forms of the disorder (Insel & Akiskal, 1986).** It is becoming increasingly clear that such clients belong within the spectrum of OCD although they may be more resistant to treatment than most of the group.

TABLE I

Definition of Criteria for OCD (DSM-III-R)

A. Either obsessions or compulsions

Obsessions: (1), (2), (3), and (4):

(1) Recurrent, persistent ideas, thoughts, impulses, or images that are experienced as intrusive, unwanted, and senseless or repugnant (at least initially).

(2) The person attempts to ignore or suppress them or to neutralize them with some other thought or action.

(3) The person recognizes that the obsessions are the product of his or her own mind and not imposed from without (as in thought insertion).

(4) If another Axis I disorder is present, the content of the obsession is related to it; e.g., it does not include thoughts about food in the presence of an eating disorder, thoughts about drugs in the presence of a psychoactive substance use disorder, or guilty thoughts in the presence of a major depression.

Compulsions: (1), (2), and (3):

(1) Repetitive, purposeful, and intentional behaviors that are performed in response to an obsession, or according to certain rules or in a stereotyped fashion.

(2) The behavior is not an end in itself, but is designed to neutralize or prevent discomfort or some dreaded event or situation. However, either the activity is not connected in a realistic way with what it is designed to neutralize or prevent or it is clearly excessive.

(3) The person recognizes that his or her behavior is excessive or unreasonable.

B. The obsessions or compulsions cause marked distress, are time-consuming (take more than an hour a day), or interfere with occupational functioning or with usual social activities or relationships with others.

Similar to phobic disorders, OCD is usually characterized by avoidant behavior. However, for the person with OCD, avoidance usually does not prevent anxiety. The anxiety associated with OCD is generally secondary to an inner compelling force or expectation rather than to an external cue, such as that associated with a phobia. Indeed, one useful distinction between OCD and a phobic disorder is that in the former, avoidance cannot succeed. Although the OCD individual may describe his or her symptoms as a germ or contamination phobia, the actual cue is either invisible, ubiquitous, or unavoidable.

Symptom Clusters

It is curious that of all the ways one might obsess or ritualize, **people with OCD present a relatively restricted repertoire of symptoms.** Four of the most common syndromes are described below.

Washing:

Representing about 50% of most OCD samples, washers are obsessed with dirt, contamination, germs, or bugs (Akhtar et al., 1975). They may spend several hours each day washing their hands or showering. Concerns with contamination most frequently revolve around urine, feces, vaginal secretions, or some natural bodily process that cannot be avoided. Washers may become incapacitated by their rituals and, if they avoid public restrooms, may ultimately be unable to leave home. Resistance at times seems halfhearted. Although the client states, "I know I am not really going to contract cancer if I don't wash," one may see a truculent refusal to shake hands or to touch doorknobs. Occasionally, washers are not even certain why they are washing but express a vague presentiment that "something terrible will happen if I don't."

Checking:

A second presentation for OCD involves **pathologic doubt accompanied by compulsive checking.** Typically the "checker" fears the gas jets have been left on or that a bump in the road was a body; the doubts reveal a concern with violence. **Although some uncertainty about carelessness, particularly carelessness that could lead to catastrophic consequences, is common to us all, for the obsessional the uncertainty takes on a gnawing, malignant quality. Checking, which is enough to resolve "normal" uncertainty, often only contributes to the obsessional's doubt.** For instance, if after checking, a bump in the road does not appear to be a body, then the obsessional fears that the body may have been knocked into the bushes. **Ultimately, by some inscrutable means, the person with OCD resolves one particular doubt only to have it replaced by a new obsessional preoccupation.** Rachman and Hodgson (1980) have described compulsive checking as "preventive," because the fears are often future-oriented, in contrast to washing, which is "restorative." **Resistance, which in this case is the attempt to refrain from checking, leads to difficulty concentrating and exhaustion from the never-ending assault of nagging uncertainties.** Checkers live as if they are a guilty party perpetually in search of a crime, and, not surprisingly, they frequently describe a strict religious upbringing.

Pure Obsession:

A third clinical picture is that of the pure obsessional. **Approximately 25% of people with OCD are in this category (Carey & Gottesman, 1981). Repetitive, intrusive thoughts, usually sexual or aggressive and always reprehensible, may be associated with impulses (which have been called horrific temptations) or fearful images. When the obsession is an aggressive impulse, it is most often directed at the one person most valuable to the client and thus becomes an indirect attack on the self.** Occasionally, the thought may seem relatively neutral to the observer, but for the client, the preoccupation invariably seems laden with guilt. **Resistance, which may involve cognitive (e.g., counting or counter-thoughts) rather than behavioral rituals, may be more bothersome**

than the original intrusive thought. A client who was afraid he would decapitate his younger brother struggled with that impulse by avoiding sharp objects, then avoiding his family, and ultimately avoiding letters of the alphabet contained in his brother's name. Each time he would encounter the word "ax" or his brother's initials, he went through an extensive mental "counter-ritual" to undo the image of decapitation.

Primary Obsessional Slowness:

The final presentation is **the rare and disabling syndrome of primary obsessional slowness (Rachman, 1974).** Although slowness is a consequence of most rituals, it occasionally becomes the predominant symptom. **The person may take an hour or more to brush his teeth or two hours to eat breakfast.** One such client presented with stasis pigmentation of both ankles, a result of the 8 to 10 hours spent each day at the bathroom sink. Even though such clients may have extensive rituals and severe obsessional preoccupations, they manifest very little anxiety. **For them, life grinds on at a remarkably low speed.**

Those four presentations are clusters of symptoms but not entirely independent syndromes. In many cases, washing and checking co-exist. In addition, one sees adult clients with pure obsessional complaints who give a history of compulsive handwashing or compulsive checking during young adulthood. Thus, within individuals, the different symptom clusters may overlap or may develop sequentially.

Prevalence

The traditional reputation of OCD as "rare" is probably not accurate. Although **the administered prevalence (i.e., the number of OCD clients in a treatment population) is probably close to 1%,** with some variance depending on the treatment center (Black, 1974), people with the disorder are quite secretive, and, therefore, **one might expect the actual prevalence to be considerably higher.** The Epidemiologic Catchment Area study sponsored by the National Institute of Mental Health sought to establish the actual prevalence of several disorders by administering the Diagnostic Interview Schedule in a door-to-door survey (Myers et al., 1984). Results suggest an astonishing 1.3 to 2.0% of the general population meeting criteria for OCD. If that diagnostic method is validated and the results are replicated, OCD would appear to be more prevalent in the general population than in the average mental health clinic. One might then wonder if that tiny fraction of obsessionals who become clients can truly be distinguished by their symptoms or if some other factor, such as family conflicts, depression, or a particular personality style, might determine when obsessionals become clients seeking help. Alternatively, many OCD clients may be misdiagnosed in the treatment setting.

Little evidence is available to determine significant cultural or national differences in the prevalence of OCD. Description of the disorder from Asian, European, African, and American clinicians suggest remarkable similarities, although the preponderance of the various symptom clusters differs across settings (Hunter & MacAlpine, 1963; Lo, 1967; Rasmussen & Tsuang, 1984).

OCD is also one of the few psychopathologic illnesses that is found in children in a form nearly identical to its adult presentation. Perhaps the only distinguishing feature of the childhood form of OCD is that **boys appear more affected than girls, with a male-female ratio of three to one, whereas the sexes are equally represented in adult cohorts with the disorder (Rapoport, 1988).** The overall prevalence of OCD may be slightly lower in children, although a comprehensive community survey remains to be done for children. As many as one third of adults with OCD admit to onset of symptoms prior to age 18, often prior to puberty (Rasmussen & Tsuang, 1984).

Genetics

Sophisticated adoption studies such as those used in research on schizophrenia and affective illness are not available for OCD. Studies of the families of obsessional clients have generally yielded a high incidence of obsessional 'features'' (noninterfering obsessional thoughts or behavior) but not of obsessional disorder per se (Insel, Hoover, & Murphy, 1983). A number of reports have described identical twins concordant for OCD. Although that might indicate a genetic component for the disorder, such data are always suspect to reporting bias, because discordant pairs are less likely to be reported. Systematic twin studies, while sparse, demonstrate high concordance rates in monozygotic twins but only when the measure is obsessional features, not full-blown OCD (Carey & Gottesman, 1981). The picture that emerges from those studies is that **some predisposition to obsessional behavior is inherited; but, consistent with the preliminary epidemiologic data, the development of the full disorder leading to treatment appears to be an uncommon event.**

Pauls and coworkers (1986), in an important recent study of Tourette's syndrome, noted **OCD occurs in as many as 20% of the first-degree relatives of Tourette's clients,** a figure considerably higher than the corresponding number of relatives of OCD clients. In that study, many of the Tourette's clients also had obsessional symptoms, but, surprisingly, the high rate of OCD in relatives was not limited to those index cases with obsessional symptoms. It appears then that the two disorders, or some subtype of the two disorders, share a common genetic predisposition. Pauls and his coworkers are currently using the techniques of molecular genetics to determine if those pedigrees have a specific genetic abnormality. With those techniques it may be possible to localize the part of the genome that is altered in people with the disorder and to define specific gene products that result from this alteration. First, however, it will be important to determine what "disorder" to look for–Tourette's, OCD, obsessional features, or some combination of the three.

OCD and Affective Illness

More than most anxiety disorders, OCD shares many features of affective illness. Beyond the beneficial response to one particular antidepressant, clonipramine (Anafranil), studies of persons with OCD have revealed a number of neurobiologic abnormalities previously though to be specific to people with major depression, including **an increased rate (25 to 40%) of nonsuppression on the dexamethasone suppression test (DST), shortened rapid eye movement (REM) latency during electroencephalographic recording of sleep, and blunted plasma growth hormone response to intravenous administration of clonidine (Catapres). Those neurobiologic findings are not limited to people with OCD who have secondary depression, nor are they predictive of response to antidepressant treatment.** They serve to remind us of what perceptive counselors have known for the past century: obsessional symptoms are intimately linked to changes in affect. **Not only are obsessions common in primary depressive illness, but major depressive episodes occur in at least 50% of OCD cases.** Some chronically obsessional clients only present for treatment when they become acutely depressed. And even in obsessionals who are not overtly depressed, affective-like symptoms such as low self-esteem, guilt, exhaustion, and indecisiveness are prominent.

Obsessive-compulsive disorder might then seem a variant of affective illness, as suggested in the last century by Maudsley. However plausible that may seem in individual cases, group data are not entirely supportive of that notion. **In contrast**

to affective illness, OCD tends to be more chronic, shows a younger age of onset, and has a lower ratio of female-to-male incidence. In addition, one retrospective study found OCD to have a lower incidence than a family history of depression, but this is not true in all samples.

Neuropsychologic Findings

Several leads suggest neuropsychologic dysfunction in OCD. **Many cases of OCD appeared to evolve as sequelae to encephalitis lethargica,** a disease with well-documented neuropathologic lesions. **Grimshaw reported a high incidence of premorbid neurologic illness in addition to encephalitis in his series of clients with OCD.** One report suggests that people with "atypical" symptoms have a high incidence of **birth trauma.** Obsessionalism is evident as an interictal trait in **temporal lobe epileptics.** And finally, **discrete neurosurgical lesions have been shown to selectively reduce obsessional symptoms.**

Despite those leads, no clear evidence of a specific neurologic dysfunction has been documented. There are **conflicting reports of EEG abnormalities in people with OCD,** but even the most outspoken claims cite only nonspecific, nonlocalized findings such as increased slow-wave activity. Shagass and his coworkers (1984) have reported an increased amplitude in one of the middle latency waves of the somatosensory-evoked response. Unlike other findings of electrophysiologic abnormalities, this finding is distinct to OCD. The patho-etiologic significance of that finding remains to be determined.

Recent results using new imaging techniques have been particularly intriguing. **Some young adults with OCD appear to show atrophy of the caudate nucleus on volumetric CT scans (Rapoport, 1988). Positron emission tomography studies show increased metabolic activity in the orbital frontal cortex and caudate nucleus (Baxter et al., 1987).** Current research is leading toward a hypothesis regarding abnormal frontal-striatal activity in at least some people with OCD. Although it is not yet clear if the abnormalities reported are of etiologic significance, **the therapeutic efficacy of surgically interrupting frontal-striatal pathways in OCD has been known for decades,** so that pathway may represent an important focus for treatment (Kelley, 1980).

Treatment of OCD

Of all psychopathologic conditions, OCD has generally been considered one of the most refractory to treatment. Clients with the disorder frequently present with symptoms seemingly laden with unconscious symbolism and dynamic meaning. Yet, **psychodynamic therapies, particularly if they are loosely structured and nondirective, often fail to reduce the symptoms. Behavioral approaches and pharmacologic treatments have recently been shown to offer considerable promise in OCD.**

Behavioral Treatments:

Of the number of frequently used behavioral interventions, only two have been repeatedly successful of OCD, **in vivo exposure and response prevention.** Both techniques require a thorough knowledge of the client's symptoms. **In vivo exposure includes contact with the objects associated with discomfort, contamination, or fear.** A client with fears of contamination from urine will be exposed to public bathrooms and may ultimately touch a urine soaked cloth for two hours each day, until the dread of contamination subsides. In addition, the client will not be permitted to wash, or at least not to wash excessively. **That restriction of washing, which is called response prevention, appears particularly important for decreasing compulsive behavior.** Indeed, careful studies by Steketee, Foa, and Grayson (1982) have demonstrated that for decreasing both obsessions and compulsions, the two techniques should be used together.

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The best client for behavior therapy is the washer or checker with well-defined external cues, associated avoidance, and a high motivation for change. The therapy is built around risk taking, with the client pushing himself or herself to do the very things that have seemed so reprehensible. Not every OCD client is right for in vivo exposure and response prevention. **Those with depression and those with little resistance to their symptoms may not respond.** In addition, clients with pure obsessions or those with primary obsessional slowness may not be appropriate for such treatment. Perhaps the major limitation of this form of behavior therapy, however, is the counselor. **Those techniques require a counselor with training and time. During the early phases of this treatment, the counselor may spend three hours a day with each client.** Clearly, if the disorder is as common as currently believed, that treatment can help only a tiny fraction of those with OCD.

Although behavior therapy is intense and difficult, **as many as 80% of those who undergo in vivo exposure and response prevention are much improved within a few weeks (Steketee et al., 1982).** Follow-up studies reveal continued improvement at one year following treatment, although in many cases the need for behavioral homework or brief "refresher" sessions may be helpful. Most important, **OCD clients who undertake behavior treatment rarely develop "substitute symptoms" or psychosis, although they usually fear one or both of those adverse outcomes.**

Pharmacologic Treatment:

For those clients who will not undertake behavioral therapy or those for whom avoidant behavior is not a major part of the symptom picture, medication may be especially useful. The pharmacologic treatment of OCD has recently become an intriguing area of research as well as a promising avenue of therapy (Zohar & Insel, 1987). The major finding from studies in Europe, Canada, and the United States is that the **tricyclic antidepressant clomipramine reduces the symptoms of OCD, whereas a number of structurally related antidepressants such as desipramine (Norpramin, Pertofrane), amitriptyline (Elavil), and nortriptyline (Pamelor) have not been found to be effective. Among antidepressants, clomipramine is distinguished by its potency for blocking the neuronal re-uptake of serotonin,** which is the major route of metabolism of that neurotransmitter. Several lines of evidence link the drug's serotonergic and anti-obsessional effects. **Improvement during clomipramine treatment is correlated with decreases in the serotonin content of platelets and the serotonin metabolite, 5-hydroxyindoleacetic acid (5-HIAA), in cerebrospinal fluid.** Some, but not all, studies have observed a correlation between improvement in obsessional symptoms and the plasma level of clomipramine (but not its less-selective metabolite desmethylclomipramine). **Very recently, two other potent serotonin reuptake inhibitors, fluoxetine (Prozac) and fluvoxamine, have also been found to reduce the symptoms of OCD (Price et al., 1987).**

In addition to those findings implicating serotonin in the reduction of OCD symptoms, evidence grows that **OCD clients show altered sensitivity to certain serotonin-like drugs (Zohar et al., 1987). One such drug, meta-chlorophenylpiperazine, actually provokes severe obsessional symptoms in OCD clients at a dose that is without behavioral effects in healthy volunteers. This altered sensitivity is corrected by treatment with clomipramine (Zohar et al., 1988).** Further evidence that serotonin may be involved in the pathophysiology of OCD comes from reports of increased levels of 5-HIAA in the cerebrospinal fluid of drug-free OCD clients **(suggesting increased central metabolism or turnover of serotonin)** and decreased levels of the serotonin uptake site in platelets from OCD clients (Zohar & Insel, 1987). It may be too early to integrate the emerging data into a single model but, from a simplistic view, it is tempting to contrast OCD and its apparently increased 5-HIAA in cerebrospinal fluid with impulsive sociopathy—its phenomenologic opposite—which is associated with decreased cerebrospinal fluid 5-HIAA levels. Preclinical studies have demonstrated a role for brain serotonergic systems in the modulation of aggression (Valzelli, 1984). It should not be surprising that OCD, which is replete with guilt and aggressive thoughts, might also involve some alteration of serotonergic function. During the next decade, we should learn more about which of the brain's many serotonergic pathways are involved in OCD and how those pathways alter OCD symptoms.

In the meantime, the major focus will be finding the best pharmacologic treatment. Although we now have several strong leads tying serotonin to the pathophysiology and/or pharmacologic treatment of OCD, only a few drugs are as yet available outside of a research setting, such as clomipramine and fluoxetine (Prozac), the latter having been primarily approved for the treatment of depression. **At present, clomipramine would appear to be the drug of choice in treating OCD. In certain cases, several less specifically anti-obsessional antidepressants such as imipramine (Tofranil) or the monoamine oxidase inhibitors such as tranylcypromine (Parnate) may be useful. Whatever drug is used, our current experience suggests a prolonged trial (i.e., six weeks at full dosage) should be offered before assessing efficacy and that continuous treatment may be necessary if the drug is successful at reducing the target symptoms.** This latter point deserves emphasis. **None of the pharmacologic treatments are cures—clients continue to have some symptoms, but they appear less distressed and are usually able to return to work or school.** Frequently, however, the symptoms revert to their original severity when the medication is stopped.

Therapeutic Rapport

OCD is usually a chronic disorder. Whether its cause is ultimately genetic, neurologic, or biochemical, its treatment is likely to be multimodal, including behavioral and pharmacologic approaches. In addition, a good therapeutic rapport is necessary, if not sufficient, for treatment. **In many cases, the opportunity to explore both the intrapersonal and interpersonal meanings of the disorder may be welcomed by the client.** Although such an exploration may not predictably reduce the symptoms of OCD, it may greatly help the client adjust to any aspects of the disorder that do not respond to specific treatments and to build on strengths not affected by the disorder.

In OCD, perhaps more than in other psychopathologic disorders, **there is often a very weak correlation between the severity of the symptoms and the amount of disability. Indeed, many people with years of extensive washing rituals seem to lead productive lives and only come for treatment when they develop a disabling depression. Conversely, as OCD receives more attention in the media, people with relatively mild compulsive symptoms who are disabled by severe character pathology are labeled as having OCD.** In both cases, the disorder may be present, but OCD need not be the focus of therapy. **In evaluating a client for OCD, the interviewer should elicit his or her past highest level of ego functioning as well as take a history of the various symptoms.** Similarly, therapy needs to address the entire person, not simply focus on the obsessions and compulsions.

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Questions Based on This Lesson

9. Obsessive-compulsive disorder (OCD):

   A. Was once known as scruples or religious melancholy

   B. Is another term for obsessive-compulsive personality disorder

   C. Is never associated with such premorbid traits as introversion or dependence

   D. Involves a significant loss of insight that usually approaches the psychotic

10. People with OCD:

   A. Can avoid anxiety by avoiding the object of their anxiety

   B. May experience concentration difficulty and exhaustion in their efforts to resist compulsive behavior

   C. Represent about 15% of the general population

   D. Are invariably over the age of 20

11. Which of the following statements about OCD is correct?

   A. It is never seen among first-degree relatives of Tourette's clients

   B. It never evolves as a sequellae to encephalitis

   C. It shares many features of affective illness, as shown in neurobiological assessments

   D. It is most commonly a defense against a full-blown schizophrenic breakdown

over, please...

12. In the treatment of OCD, which of the following statements is **incorrect?**

A. OCD is generally one of the most refractory psychopathologic conditions to treat

B. Intrapersonal and interpersonal meanings of OCD should be explored by the client in therapy

C. Behaviorial and pharmacologic approaches have proven effective

D. Therapy should focus solely on the client's obsessions and compulsions

Directions in Mental Health Counseling

VOLUME 1 • LESSON 4

Diagnosis and Treatment of Passive-Aggressive Personality Disorder

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EDITOR'S NOTE

We are all surrounded by passive-aggressive behavior (hopefully less than more). When such behavior becomes truly pronounced, it assumes the form of an official DSM-III-R diagnosis referred to as Passive Aggressive Personality Disorder, which may stand by itself or be coexistent with other diagnoses, most commonly affective disorders, substance abuse, adjustment disorders, obsessive-compulsive behavior, and narcissistic personality disorder.

The diagnosis of PAPD calls for at least five of the following behavioral patterns: procrastination; irritability when asked to do something one does not want to do; a deliberate slowness at work or doing a bad job, again when someone does not want to do something or as an expression of disturbed interpersonal relationships; protesting, without justification, that unreasonable demands have been placed on one; avoiding obligations by forgetting; exaggerating how good a job one is doing; resenting useful suggestions from others; obstructing the efforts of others by failing to carry one's share of responsibility; and unreasonably criticizing persons in positions of legitimate authority.

In this lesson the author presents extremely useful tactics that counselors can use in dealing with passive-aggressive behavior. Paradoxical injunctions, for example, involve making predictions or prescribing behaviors in a direction opposite to the hoped for outcome so that the client will further the treatment by attempting to defeat the counselor. Assertiveness training can be especially useful. Interpersonal approaches involve first engaging the client in a relationship similar to that which the client expects, then changing direction and pulling him into different and constructive behavior interactions.

Background

The passive aggressive personality disorder (PAPD) has had a long and varied history dating back at least to Hippocrates's "choleric temperament" and to Theophrastus's "grumbler." The psychoanalytic "oral character" captured many of the elements now included with PAPD and there have also been many other formulations of a similar cluster of characteristics identified within descriptive psychiatry and clinical psychology. It is perhaps unfortunate that the modern use (and misuse) of the PAPD diagnosis has been so much associated with the military's need to describe those individuals who rebel against discipline. In fact **it was during World War II that PAPD was first defined formally as a psychiatric diagnosis within the military nomenclature, and soon it became a leading cause of psychiatric inpatient admission and administrative discharge. Although PAPD was included in DSM-I and DSM-II, its inclusion into DSM-III was done somewhat begrudgingly and initially required that the PAPD diagnosis not be made if another personality disorder was also present. This unnecessarily restrictive stipulation has been dropped in DSM-III-R because of the realization that PAPD is commonly encountered in clinical practice and is a frequent cause of morbidity and of treatment failure.** We will discuss the methods of diagnosis and treatment for PAPD, and will present an illustrative case.

Diagnosis

The DSM-III-R criteria for PAPD are:

A pervasive pattern of passive resistance to demands for adequate social and occupational performance, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) **procrastinates**, i.e., puts off things that need to be done so that deadlines are not met; (2) **becomes sulky, irritable, or argumentative when asked to do**

something he or she does not want to do; (3) seems to work deliberately slowly or to do a bad job on tasks that he or she really does not want to do; (4) protests, without justification, that others make unreasonable demands on him or her; (5) avoids obligations by claiming to have "forgotten;" (6) believes that he or she is doing a much better job than others think he or she is doing; (7) resents useful suggestions from others as to how he or she could be more productive; (8) obstructs the efforts of others by failing to do his or her share of the work; (9) unreasonably criticizes or scorns persons in positions of authority.

Special Assessment Problems:

The PAPD diagnosis is particularly difficult to make based on one or even several interviews. Under certain conditions it is likely to be wildly overdiagnosed; under others it is very likely to be missed. PAPD is overdiagnosed in restrictive settings such as the military, prisons, or boarding schools, all of which tend to elicit passive-aggressive behaviors as an adaptive response to an environment that tends to discourage other more open forms of assertion. For an individual to meet criteria for PAPD, his behaviors must be pervasively passive-aggressive and occur in a wide variety of social and occupational situations, even those in which more direct and effective expressions of assertion are possible. A passive-aggressive response to a single circumscribed situation or stressor should be diagnosed (if a diagnosis is in order) as an adjustment disorder, not as a personality disorder. PAPD is probably overdiagnosed in adolescents and young adults for whom the behavior pattern may often represent a development reaction rather than a personality disorder.

PAPD is frequently underdiagnosed because many individuals who display the behaviors in question do so in a fashion that is very ego syntonic and outside their awareness. Such individuals are likely to blame others rather

than themselves for the consequent troubles they experience and are therefore poor informants concerning the items that make up the DSM-III-R criteria set. The diagnosis often requires especially careful systematic questioning, the use of other informants, and observations of the client's actual behavior in the treatment situation. At times, the PAPD diagnosis becomes established only after the client has been in treatment for some time.

Overlapping Diagnoses:

Clients who meet criteria for PAPD are likely also to meet criteria for a number of other diagnoses both on Axis I and Axis II. The most common concomitant Axis I disorders are the affective, anxiety, substance abuse, and adjustment disorders. The most common concomitant Axis II disorders are the dependent, avoidant, obsessive/compulsive, self-defeating, and narcissistic disorders. PAPD is a frequent problem in the treatment of psychiatric and medical disorders, particularly **when compliance with a medication regimen is crucial.** It must be realized that PAPD will only rarely occur as the only diagnosis given to a client and that the management of PAPD will vary considerably depending on the other conditions that are also present.

Treatment

The first and particularly crucial step in treating any client, but especially an individual meeting criteria for PAPD, is the establishment of **rapport and a good therapeutic relationship to serve as a foundation when things get difficult.** PAPD clients are almost by definition particularly hard to engage in a good treatment relationship and will require from the counselor a higher than usual level of **patience and empathy. The most common countertransference pitfalls are either to engage in needless power struggles (a trap for the domineering counselor) or, on the contrary, to avoid struggles even at the cost of becoming as passive as the client.** A variety of different techniques are usually necessary in the treatment of PAPD and are often particularly helpful in combination.

Paradoxical Injunction:

This is a form of therapeutic "jiujitsu" which is particularly useful with PAPD subjects because it **capitalizes on their oppositionalism, rather than locking horns with it. The counselor makes predictions or prescribes behaviors in a direction opposite to the hoped-for outcome so that the client will paradoxically further the treatment by defeating the counselor.** (Common examples include predicting that treatment won't work or that the client will be consistently late, or suggesting that the client probably has a good reason for not doing work assignments on time and should not change this precipitously, or prescribing that the client not take the indicated medicine before doing very thorough research on its side effects and complications, etc.) PAPD clients are particularly prone to fight against direct advice and so often must be guided by indirection.

Psychoeducation:

PAPD clients are likely to be very unaware of the impact they have on others and why people become so frustrated with them. They are usually much more aware of their passivity than of the inflexible oppositionalism that often accompanies it. In order for the client to become motivated to change, there first must be a **comprehensive and systematic psychoeducation about these behaviors in order that they become more ego dystonic and available for remediation.** Having clients read the PAPD section of DSM-III is often very useful in this regard and may elicit a knowing smile.

Psychodynamic Techniques:

Most PAPD clients have conscious and unconscious conflicts over attachment/autonomy. They feel and behave as if their personal integrity is threatened even by casual submission to reasonable demands (e.g., being on time), but are also **frightened that any open expression of assertiveness will be**

damaging to others or will be met by damaging retaliation. Such fears have often arisen in a family context that discouraged open and adaptive assertion and encouraged the quiet expression of power struggles. The psychodynamic approach to PAPD is to **confront the client's distortions as these become manifest in the transference** and to **interpret the unconscious wishes and fears expressed through the passive-aggressive defenses as these emerge in the client's outside life, the transference, dreams, and fantasies.** Such intrapsychic and interpersonal conflicts are then traced back to early interpersonal relationships in order to assist the client to gain greater control and distance from them.

Behavioral Techniques:

Assertiveness training is useful to allow the PAPD client to express wishes openly and adaptively, rather than in a covert and resistant fashion, and to expose the client to the anxiety experienced as a result of assertive behavior. The counselor can also assign **behavioral homework** to encourage the client to tolerate exposure to the anxiety of obeying others in situations in which this is appropriate (being on time, completing assignments as suggested, etc.). The client is taught to gain control of assertive and submitting behaviors rather than displaying a reflex tendency toward passive-aggressive avoidance. **Behavioral and psychodynamic techniques are particularly effective when used in conjunction with one another.**

Cognitive Approach:

Most PAPD subjects have automatic cognitions that they cannot and will not get their way no matter how hard they try, that they are not worth very much, that other people are making unreasonable demands upon them but that they are trying as hard as they can, and that the world is unfair and frustrating. The cognitive therapy approach focuses the client's attention on these cognitions as they arise in the sessions and also during the course of the week. The client is instructed to **keep a diary noting in systematic fashion the auto-**

matic, self-defeating cognitions associated with PAPD, the contexts in which they arise, their consequences, and the contrasting realistic appraisal of the situation. Cognitive reframing is also often useful. A client learns to understand his struggle differently when he comes to realize that an assignment submitted late may be worthless no matter how perfectly it has been done, that the boss also has his boss and his responsibilities, and that a given task has probably been assigned for reasons other than to make the client's life difficult, etc.

Interpersonal Circumplex:

The interpersonal circumplex is a sophisticated and fascinating method of measuring and mapping interpersonal behaviors and making predictions about how individuals are likely to interact with one another. Passive oppositionalism has been detected consistently as a characteristic pattern of behavior in empirical studies using the circumplex model and certain predictions have been made about the interpersonal behavior of such individuals and the likely response they will get from those with whom they interact. **Since submissiveness tends to "pull" dominance from others, and hostility tends to "pull" hostility, the prediction based on circumplex theory is that PAPD individuals will tend to bring out the hostile dominance in others**—e.g., bosses, spouses, and counselors. **This leads to positive feedback loops and self-fulfilling prophesies in which the client and his partners fulfill each others expectations and bring out the worst in one another.** The interpersonal circumplex model also makes a prediction concerning therapeutic change. **In order for the counselor to be effective, he or she will first have to engage the client in a relationship of the kind the client expects, but then change direction and gradually "pull" for different behaviors from the client. The counselor can achieve this by avoiding the tendency to act in a dominant and hostile fashion.**

Format of Treatment:

Although individual therapy is useful for many PAPD individuals, it has the disadvantage that the counselor is likely to quickly become engaged in power struggles with the client at the expense of the therapeutic alliance and therapeutic neutrality. **Family and group treatments are therefore often desirable as the treatment of choice or as an adjunct to individual treatment.** In the family or group format, the client is more likely to engage in power struggles with someone other than the counselor, which makes it easier for the counselor to point out what is going on.

Duration of Treatment:

Some PAPD clients catch on very quickly to their repetitive patterns, make decisive changes in their behavior, and do quite well in short-term treatments of 6-30 sessions. Other PAPD clients show the same remarkable stubbornness to change in treatment as they display in life and may require long treatments and great patience from the counselor. For all of the longer treatments, and for those shorter treatments that become stalemated, consultations with another counselor are often useful to keep things moving and to regain therapeutic neutrality and a more productive therapeutic relationship.

Case Example—Ms. PA

History:

Ms. PA is a 28-year-old administrative assistant who presents for treatment because she is unhappy and feels her life is going nowhere. Although she is well-educated, intelligent, and attractive, Ms. PA is stalled both professionally and in her relationships with men. She has had six jobs since graduation from college, none lasting more than one year. In each instance, she feels that excessive demands were made upon her and that co-workers received preferential treatment. Her bosses have generally expressed admiration for her ability, and affection for her personally, but they also come to feel considerable exasperation because of her unwillingness to be a "team player." They claim that Ms. PA is hard to train, misses deadlines, disregards orders, and is generally more trouble than she is worth. (On several occasions she has been told the equivalent of "in your own quiet way, you are impossible to put up with.") In contrast, Ms. PA sees herself as a hard worker who gets into trouble merely because she refuses to "brown nose" or "play office politics." On close questioning, however, she does acknowledge being consistently late for work and doing her assignments in her own way and at her own pace, but she believes that allowances should be made because her work, when finally completed, is carefully done and well above average.

Ms. PA's problems with boyfriends parallel those she has had at work. She has no trouble meeting men or in interesting them in taking her out. Difficulties generally develop only after they get close enough so that decisions must be arrived at jointly. At first Ms. PA seems charming and amusing, but boyfriends wind up complaining that (again, in "her own quiet way") she is dawdling, stubborn, oppositional, always has to have things done her way, digs in her heels over trivialities, and is never on time. Boyfriends part with Ms. PA only with considerable reluctance. Again, they say that they really like her a lot, but have come to believe that its not worth the trouble. Ms. PA is aware she decidedly has "a mind of her own" but has little insight into the degree to which her understated, but nonetheless distinct, inflexibility has impaired her professional and personal relationships.

Ms. PA is the eldest of five children of a well-organized, perhaps even overly regimented, upper middle-class family. **Both parents are psychocounselors and, in their own quiet way, they were both fanatical about achieving schedules and levels of performance from their children. They were therefore thoroughly frustrated with Ms. PA's consistent lateness and also with her underachievement in school, sports, and social life.** They tried to order her, reason with her, bully her, and even develop systematic reinforcement contingencies—all to no avail. They succeeded in forcing her into tutoring programs, music school, dance lessons, and sports camps, but she was always late for activities, uninterested, unwilling to practice, and generally so resistant that her tutors or counselors advised her parents to allow her to drop out. They were told "you can bring a horse to water but you can't force it to drink." Ms. PA was brought to several different counselors but had little or nothing to say to any of them. In her history she revealed little or no inclination to play with others as a child; her teachers were generally frustrated by her failure to come to class on time or complete her homework, but they also noted her superior potential and found her a quiet and likeable child nonetheless.

Ms. PA took six years to complete college, mostly because she had many incompletes and found it especially difficult to get papers written on time. The thing that frustrates her the most now is that even when she sets up her own schedules, which she has begun to do, she is just as unable to follow them as those schedules established for her by others.

Diagnosis:

Ms. PA meets most of the criteria for passive-aggressive personality disorder as these are listed in DSM-III-R. She has **a pervasive tendency (in work and social relationships) to resist demands for adequate performance** and this is **generally done indirectly rather than by asserting herself** in a more adaptive fashion. **She procrastinates, forgets, and is inefficient, argumentative, and stubborn. She overestimates the quality of her work and resents even well-meant advice and suggestions from others. She is constantly involved in unnecessary and unproductive power struggles. This behavior is of long standing and she brings the problem to each new situation.** Although Ms. PA experiences some mild symptoms of anxiety and depression, none of these are of sufficient severity to warrant an Axis I diagnosis. She has obsessive/compulsive personality features but these are not sufficient to meet criteria for another DSM-III disorder.

Treatment:

The counselor and Ms. PA hit it off well at first. **He took advantage of the good start to make a prediction—one that annoyed her—that the treatment had little chance of working and that it probably would not last more than a few sessions. When she asked why he was so pessimistic, the counselor cited the fact that anyone's past performance is the best predictor of future treatment behavior and benefit. He pointed out that her consistent pattern was to start well, but quickly run into difficulties of a very particular and predictable type. As the counselor expected, the client took the prediction as a challenge** and said she thought she was different now and did want treatment to work. The prediction thus served several purposes: to provide a foundation for additional similar interpretations that will become necessary when things do eventually turn sour, as a form of psychoeducation to render her behaviors increasingly ego dystonic, and probably most important, as a paradoxical injunction. Given the counselor's prediction of treatment difficulty, this young woman can defeat him only by making the treatment succeed. In contrast, therapeutic optimism is likely to bring out oppositional treatment defeatism in PAPD clients.

The next phase of the treatment took many months and consisted of a careful and systematic inquiry into the many ways in which the client's behaviors resulted in problems both at work and with boyfriends, and how these were now having a similar impact in the treatment. In order for the PAPD client to achieve the motivation to change behaviors which come very naturally, she must first become aware of them, of their consequences, and of other people's reactions. The client had often been told before that this or that behavior was annoying but had always managed to attribute the observations to the self interest or misunderstanding of the other person and to emphasize her seeming cooperativeness with others. **The counselor managed to carve out a fairly neutral position which allowed him to point out the unwitting self-defeating attitude of consistently being late for sessions as well as for her job, of "forgetting" to do agreed-upon homework assignments, and of her always saying "yes, but" to his interpretations and suggestions.**

The therapy of Ms. PA was conducted over a period of two years, once a week, and made use of a combination of a number of different, but complementary, techniques derived from the psychodynamic, behavioral, cognitive, paradoxical, and interpersonal orientations. **The counselor suggested specific behavioral exercises** (making an effort to arrive on time or even early, beginning work assignments early and doing a predetermined amount of work each day, allowing a boyfriend to choose the movie without holding a grudge). These assignments served several purposes: most directly, to teach her these new behaviors, to **expose her to the anxiety that would arise when she submitted to a schedule,** and to **increase the affect generated by her unconscious conflicts regarding autonomy and submission** so that these could be interpreted psychodynamically with greater immediacy. Whenever the client complained, as she often did, that the counselor was a regimented tyrant who reminded her of her parents, he would attempt to disentangle the realistic vs. the transference aspects of this observation and trace how she tended to introduced authority conflicts with her parents into each new situation and relationship. With a therapeutic alliance strong enough to tolerate the heat generated by this transference relationship, **the client was able to discover that she relied on her reflex lateness and oppositionalism to protect her individuality and independence.** She had failed to learn more direct and adaptive ways of asserting herself because she felt outgunned by her parents and was now unconsciously afraid that a boss or a boyfriend or counselor could, in a similar way, dominate and demean her. This situation also provoked unconscious sadomasochistic sexual fantasies that were largely unconscious; these were likely to be triggered especially in relationships with men and were defended against by her being a good girl, one who would never give in even if this giving in were symbolized in her by behavior as straightforward as being on time for a date.

In conjunction with the behavioral and psychodynamic techniques described above, the client also participated in **assertiveness training** on the presumption that her displaced and maladaptive oppositionalism would be less necessary if she were more confident in her ability to directly get what she wanted in an adaptive way. Behavioral exercises alternating compliance and assertion were systematically assigned throughout the treatment in order to provide the client with a greater sense of control over her submitting, asserting, and rebelling reactions in interpersonal relationships, particularly with people she regarded as authority figures. The implications of her automatic cognitions that submission means weakness and that assertion will be overwhelmed were explored, particularly as these appeared in relation to the behavioral exercises and to her thoughts about demands made at work.

Paradoxical injunctions became less necessary as the client became less oppositional within the treatment and also outside of it. At the outset of the treatment, however, these were often useful in shaping her behavior to improve the therapeutic alliance. **For instance, probably the most effective way of dealing with her frequent lateness was for the counselor to insist on reducing session durations from 45 to 30 minutes. He stated that given her consistent 15 minutes of lateness, this was all the time that was left anyway.** The client argued that she would still be 15 minutes late to the reduced session and that this would leave only 15 minutes—which was really not long enough for a productive session. The counselor said if the client were 15 minutes late for 30-minute sessions, he would have to take the step of reducing the session duration once again, and so on with the obvious consequences. Ms. PA began coming on time for the 30-minute sessions and soon asked that the sessions be returned to 45-minute duration. When this was done, she continued to come on time.

Perhaps the most important facilitator of change, and certainly a necessary one was the nature of the interpersonal relationship that developed between the counselor and client. PAPD individuals exhibit a kind of hostile submission in interpersonal relationships that tends to elicit hostile domination from others around them partly because they feel forced to provide the client with direction and yet are constantly frustrated in these efforts. The counselor's behavior early in the treatment also had elements of domination, but this was delivered, by and large, in a good natured and loving way which according to interpersonal theory is likely to elicit a more good natured and loving submissiveness from the client. As the treatment progressed the counselor attempted to manifest less and less direction and domination, which change in behavior, in a complementary fashion, "pulled" for less submissive behavior from the client.

Thus the counselor and client became increasingly less mutually hostile and more equal as the treatment progressed to successful termination. Ms. PA also became more assertive and less inflexibly resistant in her work and personal affairs, was soon promoted to a responsible job and became engaged.

Conclusion

There has been little systematic research on the diagnosis of PAPD and no research comparing various treatment approaches. It is clear, however, that this is a commonly encountered behavior pattern in therapeutic practice and one that occasions more than its share of problematic therapeutic relationships and failed treatments. We have discussed a number of approaches to the diagnosis and treatment of PAPD that can help the counselor avoid the pitfalls and stalemates frequently encountered in work with such clients. Perhaps most important, however, is the counselor's attitude in working with oppositional subjects. The counselor who will do best is one who can flexibly mix it up when this is the only way the PAPD client can enter into a relationship, but who can also forego a needless fight, and does not always have to be right or listened to.

Study Guide

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Questions Based on This Lesson

13. Making a diagnosis of Passive-Aggressive Personality Disorder:

    A. Is often made too readily in adolescents and young adults who are actually involved in developmental reactions rather than personality disorders

    B. Requires the complete exclusion of any other DSM-III-R diagnosis

    C. Precludes the concomitant diagnosis of affective disorder

    D. Is only important to deal with compliance problems encountered in administering medication regimens

14. In the treatment of Passive-Aggressive Personality Disorder:

    A. A good therapeutic relationship with rapport is impossible to establish

    B. It is best to avoid all power struggles, even at the risk of becoming extremely passive in one's therapeutic stance

    C. The counselor must exert a powerful, authoritarian stance to get good results

    D. Patience, empathy, and flexibility are key therapeutic attitudes

15. The tactic of paradoxical injunction involves:

    A. Adamant insistence that the passive-aggressive client forfeit his self-defeating and annoying behavior patterns

    B. The counselor making predictions or prescribing behaviors in a direction opposite to the hoped-for outcome so that the client will further the treatment by attempting to defeat the counselor

    C. Enabling the client to gain direct insight into the impact of his or her behavior on others

    D. Helping the client recognize and cope more directly with previously unconscious aggressive and assertive urges

over, please...

16. The interpersonal approach to the treatment of the passive-aggressive Personality Disorder:

    A. Requires that the counselor first engage the client in a relationship of the kind the client expects, and then change direction to "pull" different behaviors from him or her

    B. Often includes family or group therapy as a valuable adjunct to individual therapy

    C. Goes after the client's tendency to bring out the worst in him- or herself and in others

    D. All of the above

Directions in Mental Health Counseling

VOLUME 1 • LESSON 5

An Update on Post-Traumatic Stress Disorder

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EDITOR'S NOTE

Post-traumatic stress disorder is a diagnosis which most therapists and counselors automatically associate with combat duty, soldiers adversely affected by war experiences, or other dramatic kinds of stress, such as airplane accidents. In fact, one can adhere to the strict definition of the disorder, i.e. that it follows a psychologically distressing event that is outside the range of usual human experience, and still find it occurring among many clients seen in everyday practice: near drowning, automobile accidents, and the like. I have made a point of asking all clients I see in consultation whether or not they have had any such experiences; on a number of occasions they have, and not uncommonly the emotional disruption triggered by these events has not been adequately recognized, dealt with, and resolved. A kind of psychological numbing, or inexplicable episodes of anxiety, or periods of occupational or interpersonal dysfunction can be traced to such times in a client's life, setting off a series of conditions that may lead to severe depression or other psychopathological states.

Clients with PTSD may reexperience, in dreams or when exposed to things that remind them of the stressful event, the fear and helplessness that they felt at the time. Some engage in massive avoidance of stimuli that would bring the memory to mind. Many experience a generalized numbing, or, at times, its opposite, a state of increased arousal and hyperreactivity.

PTSD may start a few hours or days after the traumatic occurrence or, in its delayed form, months or even years later. An inexplicable sense of a shortened future life, difficulty falling or staying asleep, irritability, and concentration problems are common.

In this lesson, the authors explore some of the hypotheses that have been suggested to explain the nature of PTSD, including the vulnerability hypothesis, which holds that after such a distressful event, coping mechanisms are compromised and future stress produces even more catastrophic physical and emotional illness, and my own resilience hypothesis, which holds that disruption is the inevitable consequence of stress of all kinds, setting the stage for reintegration to a new and higher, more complex level of adaptation.

In the acute form of PTSD, treatment follows the crisis intervention model, where the goal is to restore the traumatized person to a pretrauma level of functioning as quickly as possible, using ventilation of feelings and support systems effectively. Chronic or delayed forms of PTSD are more complex and call for the use of a wide array of psychotherapeutic and psychopharmacologic approaches; here the outcome can be adversely influenced by factors that encourage disability rather than health, such as financial compensation for injury or environments that do not attend to the restoration of resilience and the will to be well.

- Frederic Flach, MD

Introduction

The adverse psychological effects of combat have been recognized since the Civil War, when they were generally regarded as transient anxiety reactions. After World War II intense attention focused on postwar syndromes, with special clinical interest in combat-induced stress reactions. As a result of those studies, the diagnostic category "gross stress reaction" was included in DSM-I (Committee on Nomenclature and Statistics of the American Psychiatric Association, 1952). Following the war in Vietnam, many veterans of that conflict exhibited a complex mixture of psychiatric symptoms related to their combat experience. Post-traumatic stress disorder (PTSD) was formalized in 1980 with the establishment of explicit diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders,* third edition (DSM-III) (American Psychiatric Association [APA], 1980).

Definition

Post-traumatic stress disorder is described in the *Diagnostic and Statistical Manual of Mental Disorders,* third edition, revised (DSM-III-R) (APA, 1987) as follows:

> The essential feature of this disorder is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience (i.e., outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict). The stressor producing this syndrome would be markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness. The characteristic symptoms involve reexperiencing the traumatic event, avoidance of stimuli associated with the event or numbing of general responsiveness, and increased arousal.

The Clinical Picture

The central features of PTSD (Van der Kolk, 1984) are composed of symptom clusters that include hyperreactivity with excessive autonomic system arousal, such as startle reaction, hyperalertness, or hypervigilance. Also, reexperiencing the trauma in distressing intrusive images, nightmares, and dissociative states is common. The person attempts to ward off hyperreactivity and the reexperiencing of the traumatic event with psychic numbing, constriction of affect, loss of emotional responsiveness, and decreased involvement in work and interpersonal relationships.

The disorder may begin a few hours or days after the traumatic event or months or years after the stressing event. Acute, chronic, and delayed-onset types of PTSD have been described.

DSM-III-R Criteria:

The diagnostic criteria for PTSD, according to DSM-III-R, are:

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed).
2. Recurrent distressing dreams of the event.

3. Sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated).
4. Intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma.

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts or feelings associated with the trauma.
2. Efforts to avoid activities or situations that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma (psychogenic amnesia).
4. Markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills).
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect, e.g., unable to have loving feelings.
7. Sense of a foreshortened future, e.g., does not expect to have a career, marriage, children, or a long life.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.

3. Difficulty concentrating.
4. Hypervigilance.
5. Exaggerated startle response.
6. Physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator).

E. Duration of the disturbance (symptoms in B, C and D) of at least one month.

Psychosocial Framework of PTSD

Lindy, Grace, and Green (1984) have formulated a psychosocial model for the natural history of PTSD. They suggest traumatic stress, individual characteristics, and environmental factors interplay in various fashions in the development of PTSD. Stressors may be natural disasters (earthquakes, floods), accidental disasters (motor vehicle accidents, airplane crashes), or created disasters (death camps, torture, bombing).

A variety of individual characteristics, such as early childhood experiences, preexisting psychopathology, and coping mechanisms, affect a person's tendency to develop psychological sequelae to trauma. Environmental factors such as availability of social supports may also influence the development, severity, and duration of PTSD. In general, individuals who have a good network of social support are less likely to develop PTSD, whereas those who are economically or socially deprived are more vulnerable.

When the intensity of the trauma is manageable and personality strengths and environmental resources are sufficient, the trauma is worked through and the stress reaction is limited. However, when the coping mechanisms are inadequate and the person is continually overwhelmed by intrusive phenomena alternating with avoidance mechanisms, he or she may experience psychic overload and develop PTSD.

Reactivation of a Stress Disorder

Reactivation of a stress disorder may occur following any of a variety of stressful events. Several hypotheses have been formulated on the effects of repeated exposure to stress (Solomon, Mikulincer & Jacob, 1987).

The Vulnerability Hypothesis:

The vulnerability hypothesis proposes that with each stressful event, the number of coping mechanisms that are available decreases, thus increasing vulnerability to physical and emotional illness.

The Stress Inoculation Hypothesis:

The stress inoculation hypothesis holds that repeated stress may affect health positively by rendering immunity to future traumatic experiences. Each stressful event of a similar nature would increase familiarity, lead to a decrease in the severity of the perceived stress, and result in more successful coping.

The Stress Resolution Hypothesis:

The stress resolution hypothesis holds the important factor is not exposure to stress, per se, but the outcome of earlier stressful experiences. Successful handling of a stressful event would lead to ego growth through crisis resolution, a sense of mastery, and feelings of well being as well as help in developing positive expectations about encounters with future adversities. On the other hand, if the outcome of exposure to a stressful situation is unsuccessful, it may lead to decreased self-esteem, increased distress, and doubt about future success in coping when faced with similar stress. All are factors that increase vulnerability to medical or emotional disturbance. Solomon, Mikulincer, and Jacob (1987) studied Israeli soldiers who, given the particular historical-political situation in their country, are exposed to repeated stress of battle. The stress resolution hypothesis, they conclude, predominates in their findings.

The Resilience Hypothesis and PTSD

A different approach to the conceptualization of PTSD within the framework of the resilience hypothesis has been proposed by Flach (1988). He defines psychobiological resilience as "the efficient blending of psychological, biological and environmental elements that permit human beings to successfully transit episodes of chaos necessarily associated with significant periods of stress and change." According to that theory, human beings who encounter severe trauma should be expected to be emotionally disrupted by the distressing event. The key to mental health or illness lies in "a) how the phase of disruption is managed by the individual and b) how able he is to recover spontaneously from the disruptive phase of the stress response to establish new, higher, more complex and more adequate levels of homeostasis afterwards."

Thus, Flach suggests an important question in assessing clients with PTSD is: Why have they been unable to reintegrate successfully, with or without professional help? It is important to understand the particular meaning that the traumatic event holds for the client and to stimulate his or her will to be well. That latter approach not only includes an active effort to encourage clients to create future goals and motivate them to strive toward those goals, but they may also need to reduce environmental influences that may interfere with the will to recover. Strong forces can encourage disability. The secondary gain derived from receiving caring attention, the financial compensation that accompanies disability, and avoidance of engaging in life with all its opportunities and risks is detrimental to recovery.

Prognosis

According to DSM-III (1980), PTSD may be acute, chronic, or delayed. A diagnosis of acute PTSD is based on the onset of symptoms within six months of the trauma and duration of symptoms of less than six months. A duration of PTSD symptoms of six months or more characterizes chronic PTSD, whereas the onset of symptoms at least six months after the trauma characterizes delayed-onset PTSD. (Reactivated PTSD was examined earlier in this lesson.)

Acute PTSD has a much better prognosis than chronic or delayed onset PTSD, tending to confirm Flach's resilience hypothesis. In many cases, its symptoms resolve spontaneously without counseling intervention. Chronic and delayed-onset PTSD are less common, are associated with greater impairment and disability, and have a less-promising prognosis. Recent studies by De Loos (1990) suggest that in addition to the features of acute PTSD previously described, chronic and delayed forms are characterized by a variety of somatic conditions such as somatoform disorders, which often have a symbolic value related to the traumatic experience; vegetative and psychomotor expressions of anxiety, which can take the form of exhaustion; and organic disease, especially classic psychosomatic ailments. Clients with chronic PTSD often display interactions between behavioral and organic factors, including somatoform aggravation, negation of disease, abuse of or dependence on medications, and diagnostic problems with inherent therapeutic consequences (De Loos, 1990; Wolf, Alavi & Mosnaim, 1988a).

The overall clinical picture of chronic or delayed-onset PTSD includes a decrease in personality functioning that interferes with family life, work, and social and recreational activities. Depression and guilt may lead to suicide attempts, and poor impulse control may trigger incidences of violence and result in legal difficulties. Concomitant substance abuse disorders are frequent complications of the chronic and delayed-onset forms of PTSD. Such substance abuse can also lead to aggression and legal difficulties.

Differential Diagnosis

Given the varied, nonspecific manifestations of PTSD described in DSM-III-R and the problems of comorbidity of PTSD with personality disorders, substance abuse, and other conditions, the process of diagnosing PTSD is complex. Issues of sham, as opposed to genuine, PTSD also need to be addressed, and the importance of obtaining a carefully detailed history cannot be sufficiently underscored. Factitious disorder, malingering, adjustment reactions, depression, chronic pain disorder, head injury, generalized anxiety disorder, mood disorder, panic disorder, alcohol and drug dependence, and schizophrenia are some of the conditions to be considered in the differential diagnosis. A careful history, together with a thorough work-up for organic pathology, may provide the basis for an accurate PTSD diagnosis.

Management of PTSD

Management of stress reactions after trauma in the acute phase follows a crisis intervention model, with a goal of restoring the traumatized individual to a pretrauma level of functioning as quickly as possible. In the military setting, the principles of immediacy, proximity, and expectancy in the treatment of acute PTSD are important for a favorable outcome (Solomon and Benbenishty, 1986).

Management of chronic or delayed-onset PTSD is complex, and a variety of therapeutic interventions have been employed, including psychoanalysis, insight-oriented psychotherapies, forms of group and family therapies, stress management techniques, and multiple behavioral approaches such as imaginal flooding and implosive therapy, systematic desensitization, and various pharmacotherapies. Different combinations of those forms of treatment have been used in both inpatient and outpatient settings (Figley, 1985).

Therapy in PTSD

Embry (1990) identifies seven parameters for effective therapy PTSD clients, particularly Vietnam veterans.

Rapport Building:

Establishing rapport with Vietnam veterans suffering from PTSD, who are often mistrustful of the "system" and specific individuals, requires considerable time and effort. It is important to understand the meaning of the traumatic experience for the individual and the defense mechanism he uses against perceived stress.

Limit-Setting with Supportive Confrontation:

Limit-setting is often an issue throughout therapy because clients often test their counselors to determine the constancy of their responses. The client must clearly understand the ground rules for counseling from the very beginning.

Affective Modeling:

PTSD clients present with psychic numbing, so they need to regain contact with a variety of emotions in therapy. The therapist has "to help the [client] to unlearn the 'tough masculinity' of his military experience, and actually give him 'permission' to feel" (Embry, 1980).

Defocusing on Stress:

Many clients will devote their therapy sessions to verbalizations of their traumatic experiences. From time to time, defocusing on stress issues and emphasizing the here, now, and future is necessary. That may enable the client to learn ways of minimizing anxiety-provoking stimuli at the same time it provides an opportunity to deal with the individual's ongoing problems.

Transference-Countertransference Issues:

As in any therapy or counseling situation, issues of transference and countertransference need to be confronted. The counselor who works with Vietnam veterans with PTSD is set up for rejection from the beginning, given the fact that many of those clients have significant difficulties with authority figures. The therapist and client must work together in a collaborative effort to deal with those issues.

Understanding Secondary Gain:

Vietnam veterans with PTSD have a sense of entitlement to monetary remuneration under the label of service-connected compensation or to an increase in eligibility through care status. This "quest for entitlement through what veterans call 'the maze of red tape' may take extreme proportions" (Embry, 1990). Clients may feel a need to remain sick because if they improve and are willing to return to work, they may lose their benefits but be unable to earn a living.

As noted previously, Flach (1988) has discussed the need to reduce environmental influences that may interfere with a client's will to recover and the strong forces that encourage disability while building an attitude of realistic hope.

A Positive Therapeutic Attitude:

The therapist must convey to the client his/her own belief that he/she can help the client to adjust and improve his life following trauma. The combination of a positive therapeutic attitude in the psychologist or counselor in spite of the PTSD client's testing and impulsive behavior and the client's will to get better constitutes basic terms for effective treatment.

Pharmacological Intervention in PTSD

As previously stated, the management of chronic or delayed-onset PTSD is complex and involves the use of multiple therapeutic approaches, including psychosocial and pharmacologic interventions. Recent advances in the pharmacotherapy of PTSD have been helpful in the symptomatic relief of many PTSD manifestations and have made clients more amenable to other treatment modalities.

Given the hypothesis that PTSD involves an abnormal arousal of the central adrenergic system, Kolb, Burris, and Griffiths (1984) recommend the use of beta-adrenergic receptor blockers such as propranolol (Inderal). In view of the frequency of depression-related symptoms in PTSD, several investigators have advocated the use of tricyclic antidepressants (Blake, 1986; Burstein, 1984; Falcon, et al., 1985; Frank et al., 1988). Monoamine oxidase inhibitors (MAOIs) have also been thought useful, particularly in the management of PTSD clients with such atypical depressive features as phobias, hypochondriacal complaints, anxiety, and hypersomnolence as well as for those with severe nightmares and flashbacks (Hogben and Cornfield, 1981; Shen, Nakra & Park, 1983).

Kitchner and Greenstein (1985) report beneficial effects of lithium in Vietnam veterans with PTSD and support the use of that drug in the treatment of PTSD based on lithium's reported usefulness in the treatment of clients who are prone to aggressive acting-out. Reports by Lipper and colleagues (1986) and Wolf and coworkers (1988b) suggest carbamazepine (Tegretol) may also be helpful in the treatment of PTSD.

Other psychotropic drugs such as neuroleptics, anxiolytics, and hypnotics have also been used in the treatment of PTSD (Embry and Callahan, 1988; Van der Kolk, 1983). Neuroleptic use is restricted, however, given the risk of tardive dyskinesia. Many clients with PTSD have prominent depressive symptoms, and

Wolf and associates (1985) report that subjects with affective disorders are more vulnerable to tardive dyskinesia. The use of anxiolytics and hypnotics risks development of addiction, and, given the high frequency of comorbidity of PTSD with substance-abuse disorders, prescribing such potentially addictive drugs for PTSD should be thoroughly analyzed (Freidman, 1988; Wolf, Alavi & Mosnaim, 1987).

To summarize, then, the clinical picture of PTSD may include symptom clusters related to anxiety, depression, or poor impulse control. Those symptoms would appear to respond preferentially to beta blockers, antidepressants, and carbamazepine, respectively. Additional studies using a double-blind design and quantitative clinical assessments, as well as electrophysiological and biological measurements, are needed to critically evaluate the effects of various pharmacological agents in PTSD.

Controversial Issues in PTSD

The introduction of PTSD as a diagnostic entity in DSM-III has fostered studies on the biological and clinical characterizations of the disorder. Along with rising interest in the syndrome, doubts regarding the diagnostic validity of PTSD continue to be expressed. A diagnosis of PTSD is based primarily on subjective symptoms rather than observable signs. Also, given the varied and nonspecific manifestations of PTSD, it has been argued that clients with the condition could be classified into other DSM-III diagnostic categories. Furthermore, given the high frequency of Axis I and Axis II codiagnoses in those with PTSD—particularly depression, anxiety, substance abuse, and personality disorders—a differential diagnosis is complex. Additional complications arise from factitious symptomatology, socioeconomic factors, and the malingering associated with compensation claims.

In view of the controversial diagnostic issues in PTSD, the interpretation of biological findings in this condition as well as the specificity of response to pharmacological agents—that is, whether positive therapeutic actions of various drugs represent symptomatic relief of depression, anxiety, or poor impulse control, as opposed to "specific anti-PTSD effects"—require a critical analysis.

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QUESTIONS BASED ON THIS LESSON

17. Which of the following statements about PTSD is/are correct?

    A. Chronic or delayed PTSD has a much better prognosis than acute PTSD

    B. Somatoform disorders, which often have symbolic value related to the traumatic experience, are common in acute PTSD but are never seen in the chronic or delayed form

    C. Chronic or delayed-onset PTSD often includes a decrease in overall personal functioning, with depression, suicidal ideas and attempts, and poor impulse control

    D. Rarely, if ever, does PTSD coexist with other diagnostic categories described in DSM-III-R

18. The resilience hypothesis proposes that:

    A. With each stressful event, the number of coping mechanisms always decreases, thus increasing vulnerability to physical and emotional illness

    B. Repeated stress leads to immunity to all future traumatic experiences

    C. Stress poorly handled increases ego strength, whereas that well handled decreases self-esteem and reduces resources to deal with future stress

    D. Human beings encountering severe stress will become emotionally disrupted, and the key to health is how the disruption is managed and the person's ability to reintegrate at a new, higher, more complex and competent level of function afterwards

19. Which of the following elements is/are important in carrying out counseling with PTSD clients?

    A. Affective modeling, particularly in patients with psychic numbing

    B. Defocusing away from the traumatic experience

over please...

C. Understanding and resolving secondary gain

D. All of the above

20. Post-traumatic stress disorder:

A. Is characterized by symptoms that involve reexperiencing the traumatic event, as in dreams or anniversary reactions

B. Is always triggered by ordinary stressful events, such as mild business disappointments or occasional marital conflicts

C. Is triggered by extraordinary stresses to which most people wouldn't react with any fear or helplessness

D. Never involves avoidance of stimuli associated with the event or numbing of general responsiveness

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VOLUME 1 • LESSON 6

Therapeutic Approaches to Erotic Transference

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EDITOR'S NOTE

One of the most difficult therapeutic situations arises when a client forms erotic transference. While brief, subdued, easily controlled sexual feelings and feelings of love can occur in the context of therapy and need not present serious management problems, intense, persistent erotic attitudes and behavior must be viewed as stemming from many complex levels of motivation, ranging from reliving of old problematic relationships to the concealment of hostile and even sadistic impulses.

Countertransference problems are common, requiring considerable insight on the part of the therapist. Erotic transference may be mistakenly seen where none exists. The therapist's response may be inappropriately cold and aloof, rejecting rather than analyzing the event. Anxiety and fear of things getting out of control may lead the therapist to premature interpretations of resistance and confuse his/her judgment. Insidiously, some therapists may encourage erotic transference for their own personal gratification, sexually, voyeuristically, at times sadistically.

The correct way to respond to erotic transference is by accepting it as a reality within the therapeutic context, and approaching it as a way to unearth insights in a client's past and present relationships and into the many levels of conflict and motivation that stimulate it. To minimize the risk of mismanaging a client's care or being caught up in erotic transference — even to the point of unethical and destructive involvement — therapists should readily consult with colleagues about their psychotherapeutic strategies and countertransference issues.

A "Sexist" Bias

Despite the pervasiveness of the phenomenon of erotic transference, many therapists do not receive adequate training in the effective and therapeutic management of transference feelings. One female resident who was struggling with a male client's sexual feelings toward her took the problem to her psychotherapy supervisor, an analyst. He responded by scratching his head and replying, "I don't know what you girls do about this problem." Historically, a subtle (or not-so-subtle) sexism has pervaded psychotherapy training programs. Because the vast majority of erotic transference reports in the literature, from Freud to the present, have been of female clients who have fallen in love with their male therapists or analysts, male supervisors have sometimes inadvertently promoted among their male supervisees a casual, denigrating attitude toward female clients who develop an erotic transference. One male resident who was beginning psychotherapy training told his male supervisor he was uncertain about how to approach his first client. His supervisor informed him, "It's really very simple. Do you know how to seduce a woman?" The supervisor went on to draw an analogy between "hooking" the client in a psychotherapy process and seducing a woman. This unprofessional attitude typifies an unfortunate historical trend to "enjoy" the erotic transference rather than to analyze and understand it.

Erotic Transference Defined

Since the term is used to describe a number of different transference developments, a clear definition of erotic transference is relevant to a discussion of its management. Person (1985) provided a succinct definition that applies to psychotherapy as well as to psychoanalysis: The term, erotic transference, is used interchangeably with the term, transference love. It refers to some mixture of tender, erotic, and sexual feelings that a client experiences in reference to his or her analyst and, as such, forms part of a positive transference. Sexual transference components alone represent a truncated erotic transference, one that has not been fully developed or is not fully experienced.

Neurotic vs. Borderline Content

In neurotic clients erotic transference usually develops gradually and in an atmosphere of considerable shame and embarrassment. Sexual longings for the therapist are often experienced as ego-dystonic, and the client knows that the fulfillment of these wishes would be inappropriate. Borderline clients may develop a subtype of erotic transference that Blum (1973) has termed the erotized transference. In contrast to ordinary transference love, the client in the throes of an erotized transference makes a tenacious and ego-syntonic demand for sexual gratification. Because of their ego impairments, borderline individuals experience blurring of their internal and external realities and they view their expectation of sexual consummation with their therapist as reasonable and desirable. Their seeming obliviousness to the crossing of symbolically incestuous boundaries may stem from a childhood history of being victimized in actual sexual seductions by parents or parental figures (Blum, 1973; Kumin, 1985-86).

Risks vs. Therapeutic Windows

The spectrum of transference that range from the erotic to the erotized is aptly described by Person (1985) as "both gold mine and minefield," and those transferences can set the scene for devastating countertransference acting out. Sex between therapist and client has severely stigmatized the mental health professions, has ruined the careers of a number of therapists, and has caused severe psychological damage to the clients who are its victims (Gabbard, 1989; Pope & Bouhoutsos, 1986). Surveys reveal as many as 10% of all male therapists have engaged in such behavior (Gabbard, 1989), so it cannot be dismissed as an occasional aberration of only the seriously disturbed therapist. Many of those therapists appear to be seeking a cure for themselves as well as to be making a desperate attempt to cure their clients (Twemlow & Gabbard, 1989).

The "gold mine" aspect of erotic transferences is that they provide the therapist an in vivo recapitulation of a past relationship in the present situation of the transference relationship. Such individuals demonstrate the contributions they bring to similar relationships outside the therapeutic situation. Thus a client's problems with love and sexuality can be examined and understood as they develop in a safe relationship where that client will not be exploited or abused. To gain insight into the experience without being destroyed in the process demands that the therapist adhere to four principles of technique (see Table).

STEPS IN THERAPEUTIC MANAGEMENT OF EROTIC TRANSFERENCE

1. Examination of countertransference feelings
2. Nonexploitative acceptance of erotic transference as important therapeutic material to be understood
3. Assessment of the multiple meanings of the transference in its function as a resistance to a deepening of the therapeutic process
4. Interpretation of connections between transference and both current and past relationships

Examination of Countertransference Feelings

The therapist's countertransference reactions to erotic transference feelings in the client may represent countertransference narrowly, as a reactivation of a relationship in the therapist's past; broadly, as an identification with a projected aspect of the client; or as a combination of both (Kumin, 1985; Sandler, 1976). The client may well represent a forbidden but sexually arousing object from the therapist's past, but the therapist's desire for the client may also be linked to the actual incestuous desire of a parental figure from the client's oedipal phase of development. The first step in monitoring countertransference, therefore, is for the therapist to assess the relative weight of his or her own contributions versus those of the client. Therapists who attempt to manage erotic transference in intensive psychotherapy without a personal treatment experience, however, will be at a serious disadvantage. Several countertransference patterns are related to erotic transference.

Seeing Erotic Transference Where None Exists:

Common in male residents treating attractive female clients is a countertransference pattern in which the resident sees erotic transference where none exists. Male therapists may react to their own sexual arousal by projectively disavowing it and instead seeing it in their clients, whom they label as "seductive." In those circumstances, the resident who is pressed for details about why the client is seductive, or why she is sexually interested in him, is often at a loss to present convincing evidence. Because of anxieties about his own sexual feelings, he has avoided them much as the hysterical client attempts to avoid her sexual feelings. Although such avoidance may simply reflect beginner's anxiety about having sexual feelings in psychotherapy, it may also be a repetition of the client's father's response to his own sexual arousal in the presence of his daughter (Gorkin, 1985). If beginning therapists ignore those feelings, they unconsciously act them out by make phallic, "penetrating" interpretations too often and too soon, another common pitfall of the new therapist.

Cold Aloofness:

A second countertransference reaction is cold aloofness in response to the client's confessions of erotic longings for the therapist (MacKinnon & Michels, 1971). To control any sexual countertransference reactions to the client's feelings, the therapist may become more silent, less empathic, and more distant. Such "strait jacketing" of all emotions helps rigidly maintain control of sexual impulses that seem threatening.

Anxiety:

A third common countertransference reaction is anxiety, which arises from the fear that sexual feelings, either in the client or therapist, will get out of control. That anxiety may lead the therapist to divert the conversation from the client's expressions of love or sexual arousal or to interpret such feelings prematurely as "resistance," a digression from the therapeutic task. When a male therapist inappropriately tells his female client that he will not allow the therapy to be side-tracked by her feelings for him, he forces her to concentrate on the problems outside therapy that brought her to treatment. Such an anxious attempt to eliminate erotic transference feelings may give clients the message that sexual feelings are unacceptable and possibly disgusting, a view that often mirrors the feelings of the client. The therapist's own underlying disgust may relate to the covert message in intense erotic transference that therapy is useless — that only sex or "love" can cure (Gorkin, 1985).

Self-gratification:

In the fourth countertransference pattern, which may be more insidious than the others, therapists encourage and foster erotic feelings for their own gratification. Such therapists, who listen with voyeuristic delight to the details of their client's sexual fantasies, may have been drawn to the profession because they long to be idealized and loved. Still, underneath that wish they may gain sadistic pleasure by arousing their clients' futile sexual wishes. The pattern can often be traced to the therapist's childhood interactions, in which he or she felt aroused by the opposite-sex parent only to be frustrated. By practicing psychotherapy, such individuals may be trying to reverse that childhood situation. Therapists must be aware of their own desires in the therapeutic relationship. As Kumin (1985 - 86) noted, "Both the analyst's capacity and incapacity to interpret accurately the patient's wishes in the transference require an appreciation of not only what and whom the patient desires but also what and whom the analyst desires." Kumin has also suggested the desires of the therapist for the client may present a more formidable resistance than the client's desires for the therapist. Numerous psychotherapy processes have become stalemated in the throes of intense erotic transference because the therapist has been too busy basking in the glow of sexual feelings.

Nonexploitative Acceptance of Erotic Transference as Important Therapeutic Material

After the therapist has carefully analyzed countertransference feelings, he or she must convey to the client that sexual or loving feelings are acceptable in the therapeutic experience. The therapist may make an educational comment such as, "In psychotherapy you are likely to experience a broad range of feelings — hate, love, envy, sexual arousal, fear, anger, and joy — all of which must be dealt with as acceptable topics for discussion and as carriers of important information for the therapy." While it is true that erotic transference may serve as resistance to the emergence of other material in the therapy, it is a technical error to immediately interpret such feelings as resistance. To understand what is being repeated from the past, the erotic transference must be allowed to develop fully.

Freud (1958) first used the term acting out to describe a client's tendency to repeat in action something from the past rather than to remember and verbalize it. The clients may be told the feelings that develop in therapy will provide important information about those that develop elsewhere, both past and present. If a client insists on gratification of the transference wishes, the therapist can point out that not gratifying the wishes can lead to a better understanding of what happens in other relationships. The therapist should remember that erotic transference may be intensely unpleasant for the client, just as it may be for the therapist, not only because of the frustration it brings but also because it may be embarrassing. Perhaps the therapist may wish to communicate an empathic understanding of the client's shame: "I know it is difficult and painful for you to have these feelings without being able to gratify them, but if we can explore them together we may be able to help you understand more fully the problems that brought you here."

Assessment of the Multiple Meanings of the Transference in Its Function as a Resistance

Erotic transference is a resistance in the sense that something is being repeated rather than remembered and verbalized. Resistance should not be equated, however, with something bad that must be removed immediately, as is often believed by beginning therapists. As stated earlier, erotic transference is also an important communication that should be understood. Like all other mental phenomena, erotic transference is determined by the principle of multiple function. It should not be taken simply at face value but rather should be explored through the client's associations, dreams, and memories for all its multiple meanings, some of which may be unconscious. For example, a male client's erotic transference to a female therapist may represent passive homosexual longings, even though the therapist is of the opposite sex (Torras de Bea, 1987). Because erotic transference must also be understood in terms of its function at a particular moment in therapy, the therapist must assess what preceded its development and what follows its flourishing.

Therapist Envy: A Case Study:

> One male client began his therapy session with his male therapist by saying that he had been helped enormously in the previous session by the therapist's explanation. After commenting on how much the therapist's interpretation had helped him at work, the client began to contradict what he had just said by maintaining that his relationships were deteriorating. As he continued to talk, he revealed that he had been having sexual fantasies about the therapist and that he believed the therapist could only help him by ejaculating semen into his rectum to make him more masculine. The therapist pointed out that the client was devaluing the help of the insights that he had received in the previous session by holding onto a magical belief that a sexual liaison was the only way to obtain help. The client acknowledged that he needed to devalue the therapist's help because he felt so inferior to him, who he said was "on Mount Olympus." The therapist then explained that the client's envy had increased as he was helped, so he had sexualized the transference to devalue the help. In other words, if the therapist's insights were not particularly effective or useful, there was much less to envy. In response, the client said that his liberating feelings of having been helped had alternated with feelings of humiliation

> because he was forced to acknowledge that the therapist knew something the client did not know, which made him feel vulnerable.

In that example, the client's erotic transference was a way to defend against his envy of the therapist's competence by devaluing it. Sexualization in the transference may be a way to defend against other feelings as well.

Ending Therapy: A Case Study:

> A male client was seeing his female therapist for the last time prior to her departure at the end of her residency training program. He told her that he had seen a movie the night before in which a female psychiatrist had kissed one of her male clients. He observed that the client had seemed to benefit from the therapist's affection, and he asked his therapist if she might do the same with him. After an initially anxious reaction to the request, the therapist asked if the unexpected request might be related to the termination of the therapy. The client responded that he would rather not think about that subject. The therapist then pointed out to the client that his wish to sexualize their relationship might be a defense against facing the grief associated with termination.

Sexualizing the end of a relationship is a common phenomenon, both in therapy and in life in general, serving to avoid the mourning process connected with loss of an important figure. In the vignette described above, the client's wish to become physically involved with his therapist was also a way to deny the definitive nature of termination: a kiss might lead to a beginning, rather than an ending.

Therapist's who view transference love as a natural and understandable response to their enormous sexual appeal are overlooking the darker side of erotic transference. One of the many stories told about Karl Menninger illustrates this dilemma: A depressed and hysterical 40-year-old woman was hospitalized at the

Menninger Clinic for over a year with essentially no improvement in her condition. During her hospitalization she developed an intense and intractable erotized transference toward her male psychotherapist, so Dr. Menninger was asked to consult on the case because of the therapeutic stalemate that had been reached. Throughout much of the interview, the client repeatedly commented on her great love for her therapist. After listening to her protestations of love for several minutes, Dr. Menninger reportedly said, "You know, if you really loved him, you would get better for him."

Dr. Menninger was addressing the hostility that often lies just beneath the surface of a client's transference love. Indeed, erotic transferences frequently mask considerable aggression and sadism, even to the extent that an erotic transference might be considered a form of negative transference (Kumin, 1985 - 86). A client's demands for crossing of sexual boundaries may be so tormenting, especially in instances of the erotized variant typical of borderline clients, that the therapist dreads each session. The therapist may feel used and transformed into a need-gratifying object whose only function is to fulfill the client's inappropriate demands (Frayn & Silberfeld, 1986).

Controlling the Therapist: A Case Study:

> Ms. A, a 24-year-old homosexual histrionic woman functioning at a borderline level of ego organization, had a history of sexual abuse by male relatives. She formed an intense erotized transference to her female therapist almost immediately. She flirted with her provocatively in the sessions by touching the therapist's foot lightly with her own foot and asking, "Does this make you nervous?" Ms. A steadfastly maintained that her therapist could only get to know her if she slept with her. She also demanded to know her therapist's sexual orientation. Although the therapist frustrated the client's wish to destroy their professional relationship by transforming it into a sexual one, the client continued her efforts

at seduction, regularly bringing to the sessions and reading aloud explicit sexual fantasies about her therapist that she had written. Needless to say, the client's expression of such fantasies made the therapist feel uncomfortable and anxious — as well as controlled. If she interrupted the fantasies, she felt that she was revealing her discomfort and disapproval of the client's transference feelings. If she remained silent, she felt that she was coluding in an exhibitionist-voyeur pairing. Finally, however, the client revealed some of the underlying aggressive feelings that were masquerading as erotized transference. She commented to the therapist, "You know I'm aware of still wanting to piss you off. Probably force you into rejecting me. Make you hate me. Am I succeeding? I really want you to like me. But since I know that's out of the question, I'll just drive you away." To a large extent, Ms. A had induced a paralysis in the therapist, who was made to feel cruel and sadistic by frustrating the client's wishes. A consultation helped the therapist understand that she was being controlled by a projective identification process, so the normal, professional limits of psychotherapy seemed ruthless and unreasonable. In other words, a cold, depriving object from the client's past had been projected into the therapist, who unconsciously identified with that projected material. Moreover, her own anger at the client for her relentless control of the therapy also contributed to her feelings that any intervention would appear cold and ruthless. As the psychotherapy continued, it became more clear that the overt sexual wish was only the tip of an iceberg. During one session, Ms. A reported a dream in which she was in a high-tech office. There was a machine that could translate the client's thoughts, so that she did not have to tell them to her therapist. The client acknowledged that potentially disconcerting clinical situation. However, when therapists find themselves sexually aroused by their clients, or are the object of a client's intense sexual therapist eventually helped Ms. A to see that her wish for sex was really a wish for merger — a wish that her therapist would know her thoughts without her having to voice them.

This regressive longing to return to the mother-infant symbiotic state is often a powerful component of erotic or erotized transferences in the female client-female therapist dyad. The sexualized wish may be preferable to the more threatening wish for merger.

The Connections Between Transference and Current and Past Relationships

A correct interpretation of the erotic transference will often reduce the desire and resistance inherent in transference love (Kumin, 1985 - 86). To avoid premature interpretation, the therapist may need to silently formulate the interpretation to help with countertransference desires even before revealing the interpretation to the client. The timing of transference interpretation is a matter of judgment, but a rule of thumb is avoidance of interpreting erotic transference until the underlying linkages to past relationships and to current extratransference relationships approach conscious awareness. The therapist can point out connections between the transference feelings and past relationships, as well as between the transference and current extratransference relationships. By noting that transference love is a repetition of an event from the past — asking the client if the situation is reminiscent of past situations — the therapist can lay the groundwork for interpretive interventions.

The actual transcript of a psychotherapy session that follows illustrates some of the technical approaches to interpreting erotic transference.

Ms. B was a 26-year-old married woman with a diagnosis of hysterical personality disorder. She was seen twice weekly by a male therapist in expressive-supportive psychotherapy with a predominantly expressiv emphasis. She began psychotherapy with complaints of anorgasmia, headaches, constant marital difficulties, fear of "standing on her own two feet," feelings of being unloved and unwanted, and a generalized concern that she was too dependent. Midway through the second year of treatment, the following exchange occurred during one session.

Client: My husband and I haven't been getting along. We don't see each other much, and when we do, we argue. I wanted to make you a buddy again today, but when I walked in, something changed. I don't know what to say today. I'd like to get real mad at you, but I don't know why. Probably because I need attention and my husband's not giving me any. When I don't have anything to say, it's usually because I have feelings for you — I had butterflies just now when I said that. There are two kinds of feelings I get in here — one is when I feel that you're like my dad and I want you to cradle me and give me the pat on the back. The other is when I want you to hold me real tight...(client stops)

Therapist: You had a feeling just now that stopped you in mid-sentence. What was it?

Client: I don't want to say it. It's ridiculous. (with great hesitation) I can't just come in here...and look at you...and think, "I want to make love with you." I can't feel that way. That's not me.

Therapist: To think that you could have sexual feelings is so unacceptable to you that you cannot own the feelings as yours?

Client: I'm just not like that. Not even with my husband. My subconscious wants to hang on to you and hold you tightly, but my conscious mind wants to pretend I don't have the feelings. I'd rather go back to just having the feeling that you were like my dad and I need a pat on the back.

Therapist: It's particularly unacceptable for you to have sexual feelings for someone that you also view as a dad. I wonder if the same thing happened as a little girl in your relationship with your father.

Client: I was always very special to my dad. When he walked me down the aisle and gave me away at the wedding, he told me that I was always his favorite of his three daughters. I shouldn't be talking like this. I have to go out and get in the car with my husband and spend the evening with him, but my thoughts are going to be about you.

Therapist: It sounds like there is a similarity between your attachment to me and your attachment to your dad in that both make it difficult for you to invest emotionally in her husband.

In the above discourse, the therapist draws a connection between the client's erotic transference and her feelings for her father. Sexual feelings are forbidden in both relationships, because she sees them as incompatible with her otherwise paternal view of the therapist and her father. After linking the transference feelings to the client's past relationship with her father, the therapist connects those longings to her difficulty with her husband, a current extratransference relationship.

Seeking Consultation

The approach to erotic transference outlined in this lesson provides a conceptual framework that may assist the counselor in understanding and managing a potentially disconcerting clinical situation. However, when counselors find themselves sexually aroused by their clients, or are the object of a client's intense sexual desire, consultation with a colleague is advised. Poets have known for centuries that desire may cloud judgment. A colleague's objective feedback may help a therapist steer a truer course through the turbulent seas of erotic feelings in therapeutic relationships.

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QUESTIONS BASED ON THIS LESSON

21. Which of the following statements is correct?

    A. Most reports of erotic transference in literature address the issue of male clients attracted to female therapists

    B. All sexual and affectionate feelings felt by a client toward a therapist necessarily stem from transference

    C. Tenacious, ego-syntonic demands for sexual gratification commonly characterize erotic transference in neurotic clients

    D. In borderline clients, the obliviousness to the crossing of symbolically incestuous boundaries in erotic transference experiences may often be rooted in childhood sexual victimization by parents or parental figures

22. Erotic transference:

    A. Should be rapidly terminated by psychopharmacologic means in all cases

    B. Can readily stimulate countertransference reactions demanding serious and useful insight by the therapist into his or her own personality

    C. Is of no value in serving as a way of analyzing the client's past or present love/sex relationships outside the therapeutic context

    D. Only occurs in hysterical clients

23. Faced with an erotic transference situation, the therapist should:

    A. Make clear to the client that erotic feelings are unacceptable in the context of therapy

    B. Immediately interpret such feelings as resistance

over please...

C. Grant that he or she would very much like to fulfill the client's erotic desires, but that official sanctions against such behavior are the only reason for not doing so

D. Point out that the experience offers a valuable opportunity to explore similar feelings in the client's past or present relationships

24. Commonly seen countertransference problem(s) in response to erotic transference is/are:

A. A tendency to see erotic transference where none exits, especially among male novice therapists

B. Anxiety, stemming from the therapist's fear things will get out of hand and often leading to premature interpretations of resistance

C. The therapist's encouragement of the client's erotic feelings for his/her own gratification, often originating in voyeuristic or sadistic tendencies

D. All of the above

Directions in Mental Health Counseling

VOLUME 1 • LESSON 7

Forgiveness

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EDITOR'S NOTE

One of the most common obstacles to recovery among clients is the inability to forgive. Ironically, the process of forgiveness has received little attention in literature. Guilt, whether justified or not, can intensify and prolong states of anxiety, depression, and other forms of psychological distress. Resentment — the persistent bitter and hostile feeling state directed against those who have injured the client in fact or fiction — often contributes to an enduring state of emotional dysfunction and obstructs the creation of new, healthier lifestyles and inter-personal relationships.

In enabling clients to cultivate the art of forgiveness, it is important to distinguish between true forgiveness and pseudoforgiveness. In the former instance, the full impact of an event or someone else's injurious behavior has been recognized and reacted to appropriately, before the process of letting go is undertaken; in the latter instance, a client may have denied the meaning of the event and blocked out adverse emotions which may have to be recalled and faced prior to forgiveness.

Introduction

A most intriguing distinction: forgiveness does not have to lead to reconciliation. While reconciliation — the reestablishment of a damaged relationship with a parent, spouse, or friend for example — requires a precondition of forgiveness, forgiveness does not insist that reconciliation follow. Until forgiveness, "you can't go home again," as Thomas Wolfe wrote; after forgiveness, you can, but whether or not you choose to do so is up to you. Fransen (1964) wrote, "Man has to be saved from himself, gently and adroitly extracted from that circle in which the hardness and clumsiness of adults, as well as his own sinful tendencies have enclosed him."

Forgiveness in Psychology Literature

On examination, most psychology and psychiatry texts give the distinct impression that these fields concern themselves with problems of guilt but have a poor grasp of its counterpart, forgiveness. Rage, anger, hostility, and various forms of violence are major topics in current literature. Resentment is known to perpetuate psychopathologic states as well as personal and family unhappiness. It is a major deterrent to constructive learning and insight. Yet references to reconciliation, forgiveness, pardon, or apology rarely appear. Higgins (1959), writing in the first edition of the *American Handbook of Psychiatry,* stated, "Most psychiatrists would disclaim that they function as 'forgivers'." Sixteen years later, in the second edition of that same text, Friedman (1975) wrote, "Tacit forgiveness in the form of noncriticism is enormously important in the early stages of therapy."

Focus on the pathological has typically been the province of the physician, because sickness needs definition and clarification. A great deal of clinical observation and careful assessment of data has more than once brought about revision of the APA's diagnostic and statistical manual. The physician's concentration on disturbance seems to have lessened his or her need to describe the components of its resolution. The terms of healing, the definition of health, and the components of integrated living, therefore, do not demand — or perhaps even allow — the same degree of clarity and the same careful exposition that mental illness in all its complexities seems to receive.

The Response to Suffering

Mental health professionals are burdened with their intimate knowledge of the extent of human depravity and the harsh realities of human emotions that cause their possessors to destroy the emotional, and at times the physical, life of self or others. Such professionals, who witness the varied emotional atrocities in the lives of their clients, cannot remain untouched. Nor can those who work with the mentally ill be completely immunized against the contagion of what they encounter in their work. Personal analysis, quality training, supervised experience, and healthy ego boundaries do not fully protect the counselor, for all these encourage — even mandate — an empathy that fosters counselor identification with the client's experience.

The mental health professional may respond in a variety of ways as she or he watches the reenactment of earlier life trauma. Some may develop distancing techniques, which can lead to a degree of insensitivity that makes the suffering of clients seem unreal. Does that posture make them collaborators in the induction of the suffering? More often, perhaps, some therapists accumulate smoldering rage toward those in their clients' lives who perpetrate injustices that bring the emotionally wounded to their consulting rooms. Because they are unable to reach the objects of that rage, they will sometimes displace it onto their clients, who are now seen as enablers of their own victimization. Hence, the often-mistaken presumption that clients who suffer at the hands of others are inherently masochistic is made.

Another response is available to mental health professionals faced with the grim data of inhumanity to others: forgiveness. Karl Menninger (1966), in a plea for an alternative of forgiveness, wrote, "The vicarious use of the criminal for relieving the guilt feelings of 'innocent' individuals by displacement is no recent theory, but it constantly eludes public acceptance. The internal economics of our own morality, our submerged hates and suppressed aggressions, our fantasized crimes, our feeling of need for punishment — all these can be managed in part by the scapegoat device. To do so requires this little maneuver of displacement, but displacement and projection are easier to manage than confession or sublimation." One might add, "...than forgiveness."

Without forgiveness, violence may easily be transplanted to the victim and becomes a new source of ferocity. As Benda (1969) wrote, "We are now confronted with a growing hostility and violence that is bound to disrupt the whole social organism. The neurotic of our time is reared in a 'fatherless,' loveless, and often emotionally deprived childhood, the terror of which only the psychoanalytically trained counselor can fathom. Psychoanalysis believes that the incessant return to childhood experiences may wear out the intensity of the hate and resentment that was generated in those years and is now rekindled." The critical question in therapy is this: Does the flame of hate and revenge really burn out by itself or is something more required?

Without entering into a discussion of the sacred complications that require a person to forgive to be forgiven, as expressed in religious teaching, one may ask if the concept of forgiving is not a psychological-spiritual force that truly enables a person to permit injustice and insult to be constructively forgotten rather than forgotten out of hand.

A World Without Villains

It seems to me there is a strong tendency today to unnaturally separate victims from victimizers. Today's horror over the slaughter of innocent people in a civil uprising is forgotten in tomorrow's news of the victims of terrorism, just as the realities of suffering that engulf the victims of poverty are lost in headlines about child abuse. So, a victim of rage, greed, perversion, or prejudice moves into public notice and pushes the preceding victim from our attention and often from memory. The legal system has created the concept of victimless crimes, and society is creating a category of crimeless victims — persons who are victims with no one to blame or hold responsible. Prejudicial attitudes further victimize by placing certain persons in this crimeless victim category to suggest rape victims are at fault, poor people create their own condition, victims of racial prejudice deliberately incite hostility in others, and persons with AIDS are responsible for their disease.

That trend clearly interferes with an adequate resolution of victims' (and clients') trauma. If brutality and oppression stimulate anger and resentment toward the brute and the oppressor, what happens when the source of the atrocity is hidden by time, distance, or public opinion? Can significant anger be resolved if contact is lost with those who aroused it, whether it be directed toward perpetrators in the client's own small personal world or those who operate on a much larger scale? If those who victimize are too rapidly removed, too quickly forgotten, or too carefully concealed, their victims may not have the moment to experience their own anger, a necessary preliminary step toward resolution through eventual forgiveness.

The Theological Aspects of Forgiveness

Forgiveness can be viewed in a number of ways. For many it has a predominantly religious meaning associated with sinfulness or moral wrongdoing. In most theological systems, the repentant sinner is assured divine forgiveness and eternal blessedness. Moral forgiveness, however, has different interpretations in different religious groups. For some evangelicals, repentance is a one-time event. Having repented and accepted Jesus, the sinner is saved, and future moral transgressions seem not to be tallied against those who are saved. Theoretically, a person who has accepted Christ will no longer be prone to further moral deviation, but practically the just person continues to fall "seven times seventy." Other believers in repentance and forgiveness strike a more stringent bargain. Divine forgiveness is predicated on repentance, making amends, and improving behaviors. The past is forgiven but not forgotten, because distinct contingencies remain.

One of the two great sins for some believers is despair, which involves a personal judgment that God will not grant forgiveness because of some unpardonable transgression. In other words, that person has committed the unforgivable, unpardonable offense, the sin of the betrayer, Judas. However, that idea of unforgivability seems to be a two-edged sword. The sinner, believing he or she has committed an unpardonable sin, concludes God will not grant forgiveness. By that act, the sinner commits the sin of despair, which is unpardonable. Such reasoning seems tailor made for the seriously depressed person.

In the Jewish religion, the omnipotent and omniscient God forgives the person's sins dependent on repentance and atonement. "That is why Yom Kippur does atone for sins against God. The greatest sin is against the God within the self. Actually we confess our sins against ourselves on Yom Kippur. To atone for this we need to have a sense of self-awareness as well as to commit deeds of loving-kindness to others" (Sandrow, 1956). In the Christian religion, one of the purposes of Christ's death was atonement for man's sin. Through the confessional, the sacrament of penance provides the sinner with the opportunity for God's forgiveness. Jesus, dying on the cross, presents the vivid model of forgiveness: "Father forgive them, for they know not what they do."

Psychological Dimensions of Forgiveness:

Forgiveness has various psychological aspects, and one might ask how they fit into the range of human responses. Pattison (1969) described a punitive model of forgiveness: "Psychological guilt feelings can be resolved by appeasement, restitution, paying back or making up. Here, punishment is the price one pays to the superego to stop making one feel guilty. This is what I call the punitive model of forgiveness, which is not forgiveness at all." Pattison continues with a description of the reconciliation model of forgiveness: "Here it is learning to accept oneself when one realizes that one is unacceptable; and seeking reconciliation from the estrangement one's behavior has brought."

Superficial forgiveness, a social nicety, is practiced by most people. Rudeness is relieved, irritations are smoothed, and breaches of etiquette are healed by simple pardons. For most persons, small offenses require no more than a simple, "I'm sorry. Please forgive me." Deeper wounds that alienate one person from another require a "reconciliation model of forgiveness," for those serious ruptures of relationship are not repaired by simple phrases. In such situations the behavioral manifestations of forgiveness are not the primary means for correcting the matter. The vital characteristics of such forgiveness, the internal change of heart, needs to occur. Dictionaries have defined forgiveness as a giving up of resentment against or a desire to punish. To forgive does not require an outward manifestation but it does require an internal conversion. To be reconciled requires an outward manifestation of that internal conversion.

Cunningham (1985) wrote, "Forgiving is not for the weak-hearted or those who seek easy answers. Forgiving is indeed one of the truly courageous acts of the will. Forgiving is a power that challenges one to grow yet no one escapes the call to forgive or is exempt from the need for the healing that forgiving provides."

Psychodynamics of Forgiveness

A person's ability to forgive others reflects the forgiveness that person experienced from early authority figures. Forgiveness patterns in families also appear to affect major behavior patterns in offspring. Blum and colleagues (1972) reported children from families that emphasized love, forgiveness, and physical affection were at low risk for involvement in drug abuse. Persons who grew up in a strict family setting with powerful religious sanctions were more likely to be familiar with a punitive model of forgiveness. They forgive by "paying back or making up," and they expect the same from others. Those who were raised in a home with a religious setting that acknowledged the mistakes and shortcomings of parents and other authorities as well as those of children find the forgiveness of self and others a natural response.

Obstacles to Forgiveness:

Then there are those whose home life or religious environment was strongly authoritarian but who discovered those strict principles were not observed by the authorities themselves. In that regard, Erikson (1950) comments, "One of the deepest conflicts in life is the hate for a parent who served as the model and the executor of the superego, but who (in some form) was found trying to get away with the very transgressions which the child can no longer tolerate in himself. The suspiciousness and evasiveness which is thus mixed in with the all-or-nothing quality of the superego, this organ of tradition, makes moral (in the sense of moralistic) man a great potential danger to his own ego and to that of his fellow man." Needless to say, forgiveness in those individuals comes only after major insights.

Self-righteous attitudes make it difficult to ask forgiveness or offer forgiveness. A sense of entitlement that sometimes borders on grandiosity surrounds the self-righteous and insulates them from the humility that makes forgiveness possible.

Genuine forgiveness brings one into contact with one's own primitive emotional forces, a truly humbling experience. "Forgiving is not a nice and neat endeavor to undertake. On the contrary, it means a willingness to dirty oneself with realities that are painful in others as well as in one's self" (Cunningham, 1985). The unforgiving individual takes a psychological position that indicates the offending other is an alien — identifiable but not understandable — with some wickedness or perversion that the nonforgiver cannot comprehend because it is inconsistent with the nonforgiver's experience. On the other hand, the forgiving individual acknowledges a degree of understanding of the offender because they share a common humanity, and the dark side of one borders the depravity of the other. From that understanding and emotional proximity springs forgiveness.

Refusal to forgive others can be a controlling maneuver. Some persons seem to choose to suffer and refuse to forgive those who have offended them, although they characteristically expect forgiveness for any offense their condition pushes them to commit. They suffer so that others may feel guilty. Karen Horney (1942) described them well: "To put it briefly, his suffering accuses others and excuses himself! It excuses in his mind everything — his demands, his irritability, his dampening of the spirits of others. Suffering not only assauges his own self-accusation, but also wards off the possible reproaches of others. And again his need for forgiveness turns into a claim. His suffering entitles him to 'understanding'. If others are critical, they are unfeeling. No matter what he does, it should arouse sympathy and the wish to help."

Some find genuine forgiveness of others an impossibility. They seek retribution for any wrong to themselves, and they will not rest until they find it. They tend to exaggerate any offending act of another, and they frequently try to elicit support from others in their continuing grudge. "Vengeful people are unforgiving, remorseless, ruthless, and inflexible. At the extreme, vengeful persons live with but a single object in mind, to get even. They seek revenge against all odds and no matter what the cost and experience no guilt, no concern for possible moral or other consequences of their revenge. Here again, the paranoid motifs of injured narcissism and victimization at the hands of persecuting objects are evident." (Meissner, 1984)

Forgiveness in Therapy

The field of religious counseling or pastoral counseling uses forgiveness as a routine counseling technique (Worthington, 1986). Remarkably successful 12-step programs, like Alcoholics Anonymous, Gamblers Anonymous, and Overeaters Anonymous, advocate admission of wrongdoing, acknowledgment of character defects, humility, and making of amends. Those are the ingredients of genuine forgiveness.

In view of the successful use of forgiveness in some therapeutic settings, it is appropriate to question the role and importance of forgiveness in formalized therapy. No doubt, feelings of guilt bring many into the therapeutic contract. "Strangely, it is the inability to externalize, to stop feeling guilty, to stop punishing themselves that leads many upper status neurotics to the psychoanalyst's couch" (Langner & Michael, 1963). Those feelings of guilt are often not attached to actual aggression and so need to be resolved in an arena other than that of pardon. However, genuine aggressions, true assaults, emotional and physical abuse, or neglect seeks forgiveness as a therapeutic outcome. That process takes two complementary directions in therapeutic work – forgiveness of self and forgiveness of others. "The fact is that it is very difficult to be loving, respectful and forgiving toward others if one is not loving, respectful and forgiving toward oneself" (Tyrrell, 1984).

Clients frequently recount life events that have caused them severe emotional trauma in the past and that continue to cause emotional havoc in the present. At times those clients are not aware of the emotional trauma their anamnesis suggests. They report facts but not feelings; they describe disturbing events but are not disturbed. Therapy attempts to supply tormented flesh to the skeleton of the past.

The Dangers of Premature Forgiveness:

Some clients attempt to forgive the past too soon. They forgive in order to forget, and in such forgetting they neither resolve the conflicts of the past nor genuinely forgive those who have wronged them. Their forgiveness provides neither understanding of nor freedom from the past. Their forgiveness of others may depend on one of several mental mechanisms of false forgiveness. Denial is such a mechanism of false forgiveness. "It did not happen, and therefore I have nothing to forgive," says a client who denies sexual molestation involving an older brother. She finds no cause to exercise forgiveness toward him, but she cannot understand her emotional discomfort when he is present.

Another mechanism of false forgiveness is that of identification: "The aggressor was justified in the attack, and I would do the same under those circumstances." A client recalls the physical abuse he experienced at the hands of a parent but professes to have been such an unruly child that such punishment was necessary. However, continuing conflicts with authority figures interfere with successful and productive work.

Reaction formation is another mechanism of false forgiveness. An abused child may be filled with rage that threatens to be ego-disruptive. The child may adopt a posture of forgiveness that spares ego integrity and prevents hostile acting out. That process drains off energy and the client may lack motivation in various aspects of life.

A 40-year-old client, who was intelligent, affluent, and well educated, could not channel her energies in an organized and consistent manner. She attempted to achieve a number of worthwhile goals, often devoting her talents and her financial resources to benefit others. However, in any venture she was unable to assert herself in a positive manner, and she soon became frustrated and discouraged. She complained that others took advantage of her.

In therapy it became obvious that she continued to be a pawn in her parents conflicted marriage. The rage she had experienced as a child because of her parents' serious neglect had been repressed, and she had become their caretaker early in life, on the surface forgiving their neglect, because "they were busy and couldn't help it." When she rekindled her rage by reliving many of the traumatic events of those early years in therapy, she could then allow her resentment to be expressed in nondestructive ways. As she explored the reality of parental neglect she could accept the resultant trauma and acknowledge its influence on her life. As her anger surfaced and was expressed, and as she acknowledged her duty to live her life responsibly with all the events of her past, she could finally give up resentment against her parents. She no longer needed to punish them. She could forgive them in a deeper sense, no longer needing to engage in the superficial pseudoforgiveness that had allowed her to repress her anger. Her affective energies were freed by those therapeutic gains so she could effectively carry out projects that were fulfilling to her and beneficial to others.

Successful therapy frequently results in an increased capacity to forgive. Kohut (Baker & Baker, 1987) theorized, "Repeated empathic failures by the parents and the child's responses to them are at the root of almost all psychopathology." Coupled with that recognition of failure, however, is the therapeutic goal to acknowledge "these actual failures are unintended and beyond the parents' control, having as their root cause the psychological limitations of the parents themselves." The outcome of therapy and the resolution of past trauma should then bring the client to a point of forgiveness.

Forgiveness of self and of others does not make the self or others guiltless. Innocence is not recaptured. However, forgiving restores "integrity to one's self and one's relationships to others and [for those who believe] to God. It at times restores and renews relationships. It at times frees one to end relationships or at least turn them loose in ways that makes the brokenness more meaningful and manageable to carry. Forgiving is an act of the will that seeks wholeness and opens one's self to the expensive process of change and transformation. It is a process of willing that allows one to be less willful, less demanding and less dogmatic" (Cunningham, 1985).

Case Study

Bill, a 42-year-old man, was admitted to a psychiatric unit with symptoms of acute depression superimposed on a 12-year history of mild to moderate dysphoria. He had married at age 26, and he and his wife had two sons, aged 8 and 13. His presenting illness began approximately six weeks prior to his admission, but he was not aware of any changes or conflicts in his job, family, or social life that could have triggered his current illness. However, on admission he mentioned his older son had been confirmed in their church two months ago.

Upon careful evaluation, it seemed clear his dysphoria began shortly after his father died 12 years ago, even though he felt he had handled his father's death quite well. He was an only child. His widowed mother was still living in the family house, keeping active with personal interests and friends, and she had in no way been a burden since his father's death. When Bill used the term "burden" he elaborated spontaneously, "Why did I feel so burdened after my father died? I began to carry around some awful weight, and I didn't know where it came from."

In therapy, he reviewed his relationship with his father. He described him as "a good man, dedicated to others, hard working, a good provider." His father, a pharmacist, owned and operated the only drugstore in the town where Bill grew up. His father was truly dedicated to the pharmacy, opening it 365 days each year and even leaving the family table at mid-day on holidays to tend the store. Bill's father never attended any of the important events in Bill's early life. School functions, athletic contests in which Bill participated, Bill's involvement in school plays and debates – none found Bill's father present. Bill's mother always explained the pharmacy kept his father from attending, but Bill knew his father had time to serve on the city council, the hospital board, and the church advisory group as well as spending many hours each week with a philanthropic organization to help raise funds.

As Bill talked about the past, he initially defended his father, as his mother had done, by asserting he needed to be at the pharmacy: after all, his father was the only pharmacist in town. Bill denied his anger initially and went to considerable effort to avoid criticizing his father. In one therapeutic session, he was discussing religious events in his own life. Suddenly he hesitated and then said very quietly, "He didn't love me. He didn't care. I hate him." He had remembered the day of his confirmation. It was a Sunday, and his maternal grandparents, one maternal aunt, and two paternal uncles and their wives had been present. Following the 2 p.m. ceremony, his mother served dinner for all the relatives at 5 p.m., expecting Bill's father home from the store. He did not come to the confirmation, which was a very significant event both in Bill's religion and among the family members, nor did he come home for dinner. His philanthropic organization had been supporting the medical care of a hospitalized 4-year-old child, and Bill's father spent three hours that evening at the hospital. Bill's mother did not encourage Bill's experiencing of, or expression of, anger. "Your father is a fine man to work so hard and do so much for others."

Bill's son had been confirmed in a similar ceremony eight weeks before Bill was admitted to the hospital. Following the confirmation service, Bill and his wife invited several relatives and friends for dinner. Bill experienced the beginning of marked insomnia that night. The following day he remembered being irritable toward his son and recalled that he began to think of him as "a spoiled brat who has everything."

In continuing therapy, Bill reviewed the repeated events from which his father was absent and his own repressed feelings about the neglect he had experienced. His father had been admired and loved by many, and as a result his funeral was the largest ever held in that city. People talked about how helpful he had been, how he had been able to share their burdens and somehow lightened their load. His father's death left Bill feeling more burdened than ever before by his resentment toward his father — a resentment which his mother had not let him express, which was inconsistent with the view held by the rest of the world, and which was now locked inside him by his father's death. His son's confirmation served as key to that storehouse of repressed resentment.

Bill moved from bitter anger toward his father to a deeper understanding of him and of his "repeated empathetic failures." That understanding was not shaped by his mother nor formed by public praise but came about with an understanding of Bill's needs, his father's limitations, and the pressures of realities as perceived by his father, his mother, and the townspeople. With that understanding, he could now forgive what had been and accept the loss of what might have been. In the process of forgiving his father, he also came face to face with his own limitations as a parent, acknowledging how quickly and easily his repressed anger had recently been focused on his son. He admitted had he not come for professional help, their relationship might well have deteriorated. Bill's depression improved rapidly with the resolution of that early father-son conflict, which had begun to be reinacted between Bill and his son. Bill forgave his father for his limitations and in forgiving him, learned to accept his own limitations as a parent.

Conclusions

Forgiveness requires a change of attitude toward those who have committed wrongs and, in a sense, puts an end to some of the damaging consequences of wrongdoing. Lack of forgiveness perpetuates harmful sequelae of offensive acts, because the spirit of anger, resentment, hostility, and retaliation remains alive. It is only forgiveness that keeps the violence of the perpetrator from being transplanted to the heart of the victim.

Forgiveness of itself does not bring about reconciliation. It is primarily an internal act and does not require external demonstration. Without forgiveness, reconciliation is impossible; but without reconciliation, an individual can still achieve the emotional calm that forgiveness of others provides. Although forgiveness of others may not appear as an explicit goal of therapy, the healthiest resolution of past trauma includes an element of forgiveness. A client's acceptance of his or her own humanity and that of others, an acknowledgment of weaknesses and shortcomings of self and others, a recognition that good intentions are not always translated into action — those practical results of psychotherapy motivate a client to forgiveness of self and others. Good mental health encompasses that capacity to forgive.

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QUESTIONS BASED ON THIS LESSON

25. Which of the following statements is/are correct?

    A. Facilitation of the art of forgiveness has received extensive coverage in therapeutic literature

    B. The incessant return to traumatic childhood experiences in the course of therapy will eventually exhaust clients' resentment

    C. All efforts to teach forgiveness to clients should be religiously oriented

    D. When sources of atrocity are hidden from view by time, distance, or public opinion, recognition and resolution of the victim's anger can be significantly thwarted

26. Reconciliation:

    A. Means to give up resentment against or a desire to punish someone

    B. Only requires an internal conversion or change of heart

    C. Is the outward manifestation of the internal conversion that accompanies forgiveness

    D. Refers to the superficial forgiveness that is a social nicety practiced by most people in response to minor slights

27. Feelings of guilt are:

    A. Best managed in therapy by identifying whether they are reality-based or not and, if so, then discovering a route to acceptance and self-forgiveness

    B. Best handled by denial and projecting blame onto others

over please...

C. Never a result of nor lead to a depression of mood

D. Always unfounded and reflective of a neurotic disposition

28. To whom is the statement: "Repeated empathic failures by the parents and the child's responses to them are at the root of almost all psychopathology" attributed?

A. Freud

B. Jung

C. Kohut

D. Horney

Directions in
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VOLUME 1 • LESSON 8

The Risk of Diagnosing Physical Illness as Depression

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EDITOR'S NOTE

Physical illnesses commonly present as mental disturbances. Some statistics are particularly pertinent: For example, in one study nearly 10% of those seeking help in psychiatric outpatient facilities subsequently revealed physical illnesses accounting for their psychopathological symptoms. In another study, among patients admitted to a state hospital, as many as 46% had physical illnesses which had been previously unrecognized and which were related to their mental disorder.

Missing a physical diagnosis in a mental patient is not the exclusive failing of mental health professionals. For example, it is estimated that 48% of physical disorders are overlooked by psychiatrists, 32% are missed by nonpsychiatric physicians, and nearly 84% by nonmedical social agencies.

Many mental health professionals are not equipped to deal with physical illnesses. For many psychiatrists, for example, general medical training may be a distant memory; for others, it may never have been adequate and, even when it has been, keeping up to date is extremely difficult. On the other hand, placing one's faith blindly in the diagnostic acumen of medical specialists can often provide a false sense of security for the treating mental health professional.

In this lesson, the author highlights certain clues to help mental health professionals be more alert to the possibility of hidden physical disease. **Psychopathological states caused by brain disorders such as tumors, epilepsy, or injury are not the main focus of this discussion.** Cancer, diabetes, hypoadrenalism, hyper- and hypoparathyroidism, hyper- and hypothyroidism, infectious mononucleosis, infectious hepatitis, and a variety of other disorders are important culprits, contributing to or aggravating existing psychopathology. No matter how closely a client's condition

MISDIAGNOSIS: IS IT REALLY A PROBLEM?

Hall et al. (1978) studied **658 consecutive psychiatric outpatients and found that 9.1% of them had medical disorders that *produced* the mental, emotional and behavioral symptoms.** In an additional group of patients, medical disorders were mostly or partially causative. Forty-six percent of these patients could have been identified by their initial treating physicians, but they were not. In another study of outpatients, Koranyi (1979) excluded all patients who were immediately hospitalized as well as those patients who failed to complete a comprehensive assessment. He started with an initial sample of 2670 patients; a final sample of 2090 patients who had been completely evaluated was examined. **Forty-three percent of these patients were suffering from one or several major physical illnesses, 46% of which were undiagnosed at the time of referral; 7.74% of the total population had a physical illness which directly caused their psychiatric symptoms.** Herridge (1960) studied 209 consecutive admissions to an inpatient unit and found that at least 5% had major physical illnesses that were causative of and presented as a psychiatric disorder.

Hall et al. (1981) conducted a prospective study of 100 admitted state hospital patients. Patients with known physical disorders along with sociopathic personality disorders and persons with significant histories of alcohol or drug abuse were omitted. An intensive search for causative physical illness revealed that **46% of the patients had a previously unrecognized and undiagnosed physical illness that was specifically related to their psychopathological symptoms and either caused these symptoms or substantially exacerbated them.** Hall notes that, **"...28 of**

46 patients evidenced dramatic and rapid clearing of their mental/emotional symptoms when medical treatment for the underlying physical disorder was instituted. Eighteen patients were substantially improved immediately following appropriate medical treatments." Similar findings were found by Hoffman (1982), who reported that of 215 patients referred to a specialized medical psychiatric inpatient unit for further evaluation, the referring diagnosis was inaccurate in 41% of the cases, and 24% of cases were changed from physical to psychiatric or from psychiatric to physical illness.

Both medical and mental health professionals fail to diagnose physical illness. Koranyi (1979) reported that of all the sources referring clients to his outpatient clinic, medical personnel failed to find 32% of physical illness in referred clients, whereas psychiatrists missed 48% of physical illness in referred patients. Most striking was that 83-1/2% of all clients referred by social agencies or who were self-referred had undetected physical illness at the time they were seen in the outpatient department. Physicians are better than the patients themselves and other mental health workers in diagnosing physical illness, but their overall performance is poor by any standards.

These studies clearly show that physical illness is either a precipitant or associated condition that needs to be considered in any diagnostic formulation. More sophisticated and provocative testing techniques have been used successfully to help diagnose thyroid disease (Gold & Pearsall, 1983) and identify low-dose drug and alcohol abuse among our mental health clientele. These new tests will increase the percentage of detected medical illnesses (Gold, Pottash & Extein, 1982).

WHY MISDIAGNOSIS EXISTS

The factors which lead to diagnostic errors are important and need to be scrutinized in detail. **Many mental health professionals are unequipped to deal with physical illness in their clients.** Klein et al. (1980) feel that errors in diagnosis "cannot be attributed to random sloppiness, bad faith, or lack of desire to help a patient to the utmost." They propose a **variety of reasons which include simple lack of knowledge, educational lag in training programs, lack of continuing professional education, and resistance to new information. This can lead to a selective rejection of certain facts of the case so that the client will more easily fit into the therapist's specialty or orientation.** This often results in a distortion and misperception of the client and his sometimes obvious physical illness. McIntyre and Romano (1977) found that less that 35% of practicing psychiatrists give their patients a physical examination. Thirty-two percent of psychiatrists admitted that they felt incompetent to perform even a rudimentary physical. However, these numbers may be much greater. Mental health professionals tend to consult either the client's family doctor, internist, pediatrician, or gynecologist for a medical clearance to rule out physical disorders.

The previously cited studies refer only to physical illnesses which presented as mental disorders and were, in whole or in part, causative of the mental symptoms. Physical illness can cause or worsen the symptoms of mental illness to a variable extent. Some disorders that present exclusively with symptoms of a mental disorder are wholly causative of the psychopathological symptomatology. These disorders, if they are treated properly and have not progressed to an irreversible stage, should result in a total clearing (a cure) of all such symptomatology without institution of non-physical treatment. Other disorders exacerbate or, in part, cause the observed mental symptomatology, and, when treated, result in a significant but only partial clearing of the psychiatric symptoms. Still other illnesses are concomitant with and unrelated to the mental disorders, and, when treated, produce no effect on the mental symptoms. The group of psychopathological symptoms that develop in reaction to previously existing illness will be considered only in passing. Finally, there are mental illnesses that are often treated incorrectly as medical disorders by nonpsychiatric practitioners.

Many disorders are truly on the borderline between mental health/illness and internal medicine and neurology. Most of them are not detectable by physical examination or by "routine" laboratory screening alone. The correct diagnosis may not be made unless the consulting physician is aware of the existence of these diseases and actively pursues the diagnosis through aggressive specialized testing. As many as 50 or 100 patients with apparently similar symptomatology may have to be tested to find one patient with a physical disorder. We feel that this search is always worth it.

SPECIFICITY OF PRESENTING PSYCHOPATHOLOGICAL SYMPTOMS

From the previously cited studies and many others, it becomes clear that **no matter how closely the first presentation of a mentally disabled client may conform to classical DSM-III descriptive criteria,** one cannot assume that the client is suffering from a psychiatric disorder.

This nonspecificity of medical disease causing specific syndromes is particularly true for depressive disorders. The differential diagnosis of depression is long and involved. Giannini, Black, and Goettsche (1978) list 91 possible disorders which can present as depression. Hall (1980) lists 24 medical illnesses that frequently induce depression and 77 medical conditions that can present as depression.

To summarize thus far, many clients who present with mental/emotional symptomatology actually have medical illnesses. The psychiatric symptoms are merely the first and most obvious manifestation of the physical illness. **No psychopathological sign or symptom is pathognomonic of a mental disorder to the extent that it cannot be caused by a physical disorder.** Many non-psychiatric physicians and mental health professionals, including psychiatrists, are either unaware of these facts or choose to ignore them. A diagnosis of mental disorder is only made by exhaustive evaluation. Simply meeting descriptive criteria does not confirm such a diagnosis at any time. Most clients who present with mental/emotional symptoms are not given a thorough physical examination and medical work-up to detect possible medical causes of the psychiatric symptoms which would then be reversed by treating the primary disease.

MEDICAL ILLNESSES THAT MAY PRESENT AS MENTAL DISORDERS

The following section will review various medical disorders which can present psychopathologically and mimic any depressive illness.

THE CARCINOID SYNDROME

Carcinoid tumor may be confused with major depression, hypomania, major depression with psychosis, or anxiety. It may not always be accompanied by spontaneous flushing of the upper body precipitated by consuming certain foods or alcohol, epinephrine administration, excitement, or exertion. An attack may be accompanied by abdominal pain and diarrhea. **The syndrome accompanies a variety of tumors that can occur in the gastrointestinal tract and lungs and that secrete various biologically active substances, including dopamine, histamine, ACTH, and serotonin.** Serotonin-secreting tumors are most common.

If this disorder is included in the differential diagnosis, **the diagnosis may be confirmed by an increased urinary excretion of 5-hydroxyindoleacetic acid (5-HIAA) which normally does not exceed 9 milligrams daily.**

CANCER

Many **malignant tumors may present to the mental health professional with depressive symptomatology,** often meeting DSM-III criteria **months or even years earlier than physical symptoms or signs.**

Of all the malignant tumors that present psychopathologically, pancreatic carcinoma is the most notorious (Jefferson & Marshall, 1981). The first signs of the tumor are often severe depression with crying spells, insomnia unresponsive to sleeping medication, and anxiety associated with the fear that the patient has a very serious illness.

Central nervous system tumors present with mental/emotional symptomatology especially if they occur in the temporal and frontal regions. The most common symptom is a change in personality. Left-sided tumors present more frequently as irritability or depression, while tumors of the parietal and occipital lobes tend to be relatively silent. Limbic system tumors can present as depression, delusions, assaultive behavior, and confusional states. A high index of suspicion is indicated when the client presents in an

atypical fashion with a personality change, depression with a weight loss **greater than 20 pounds, or is unresponsive to a first trial of standard mental health care.**

DIABETES MELLITIS

In a study by Hall et al. (1981), certain clients with diabetes mellitus presented psychiatrically and met the diagnostic criteria for major depression, and for other disorders as well. Koranyi (1981) noted that **it may present as depression, sexual dysfunction, and/or marital problems.** The diagnosis is made by demonstrating an elevated fasting blood sugar or an abnormal response to a glucose load at one and two hours.

ILLICIT DRUGS

Drug and alcohol abuse and withdrawal may imitate depressive illnesses. Furthermore, hospitalized psychiatric patients sometimes abuse drugs in the hospital, resulting in confusing changes in function and severe exacerbations of their illnesses. **The only way to make the drug abuse diagnosis is to be constantly aware of the frequency of drug and alcohol problems. Simply questioning the client without formal testing is both naive and dangerous.** Drug intoxication, drug withdrawal, and the sequellae of drug abuse should be actively eliminated from consideration (Gold et al., 1982). Such clients commonly present as depression and they may meet the DSM-III for major depression. They can, however, resemble any known condition from psychosis to mild anxiety states and must be considered in all psychiatric disorders no matter how classical the presentation. Asking the client about the existence and extent of drug use is essential but anecdote should never be confused with fact. Drug use, drug intoxication, and drug withdrawal diagnosis should be confirmed whenever possible by blood or urine testing.

PRESCRIPTION DRUGS

Psychopathological symptoms occur in at least 2.7% of those taking prescription medication on a regular basis, according to the Boston Collaborative Drug Surveillance Study of 9000 patients.

HYPERADRENALISM (CUSHING'S SYNDROME) AND HYPOADRENALISM (ADDISON'S DISEASE)

Cushing's syndrome may present as an affective illness with or without psychosis, euphoria, or anxiety. In one study using structured interviews and RDC criteria, depression was present in 83% of patients with endogenous Cushing's syndrome who met RDC criteria for either mania and hypomania prior to the depression.

Hypoadrenalism commonly presents as depression or organic brain syndrome. The diagnosis is usually made on the basis of low diurnal serum cortisol and low 24-hour urine cortisol excretion, and is easily treated with steroid replacement therapy.

HYPOGLYCEMIA

Many people diagnose themselves as hypoglycemic in order to explain their depressive symptomatology. There is little proof that all such clients have symptomatic hypoglycemia. However, **there are several conditions which can cause symptomatic hypoglycemia.** The most prominent are **insulinoma** and the **exogenous administration of insulin.** Insulinoma is probably the most frequent cause of symptomatic hypoglycemia and may produce bizarre behavior that can be indistinguishable from schizophrenia, depression, dementia, or anxiety attacks.

HYPERPARATHYROIDISM AND HYPOPARATHYROIDISM

The mental/emotional disturbances seen in hyperparathyroidism are directly related to serum calcium levels. Serum calcium levels of 12 to 16 mg per 100 ml are associated with psychopathological changes. Hypoparathyroidism with resultant low serum calcium levels most commonly presents as an organic brain syndrome, but it may appear to be delirium tremens or depression with psychosis. Diagnosis of both hyperparathyroidism and hypoparathyroidism is first suspected upon seeing an abnormal serum calcium level on routine blood screening or from a history of thyroid or parathyroid disorders in the family and/or previous thyroid or parathyroid surgery.

HYPERTHYROIDISM AND HYPOTHYROIDISM

Hyperthyroidism may resemble panic disorder, anxiety, neurosis, and mania. It is not realized that hyperthyroidism **frequently presents as depression.** The diagnosis of hyperthyroidism is made by the classical signs and symptoms of hyperthyroidism along with elevated T^3, T^4, a depressed level of TSH, and a low TSH response to TRH administration.

Hypothyroidism has been classically associated with psychosis in the form of "myxedema madness." It is also associated with depression and organic brain syndromes. Gold and Pearsall (1983) have demonstrated that **there is a subtle form of hypothyroidism, "subclinical hypothyroidism," in which all the thyroid function tests including T^3, T^4, T^3 uptake**, and TSH are normal in the presence of exaggerated TSH response to the administration of intravenous TRH. Patients with an augmented TSH and titers of thyroid autoantibodies have successfully been treated with thyroid hormone alone. Furthermore, **a discrete syndrome, symptomless autoimmune thyroiditis (SAT), exists in 7-15% of inpatients and outpatients who meet DSM-III criteria for major depression.**

METAL POISONINGS

Heavy metal poisoning can occur with environmental exposure to or ingestion of a wide variety of metals including magnesium, copper, zinc, manganese, lead, mercury, thallium, bismith, aluminum, arsenic, and bromides. Most consistently, **these produce an organic brain syndrome but can also mimic major depression.**

Unless they are actively looked for with heavy metal screens by atomic absorption or plasma emission spectroscopy of urine and blood, they will not be found and properly treated. If these conditions are detected and treated early enough, the mental and emotional symptoms are, for the most part, reversible.

HUNTINGTON'S DISEASE

There is a **high incidence of symptoms resembling both mania and depression** in patients with Huntington's disease. This was noted even in Huntington's original article of 1872 in which he noted, "The tendency to insanity and sometimes that form of insanity which leads to suicide is marked." Like other diseases from hypothyroidism to folate or B^{12} deficiency, psychiatric manifestations of this disease can occur well before any of the choreiform movements or any of the signs of dementia.

INFECTIOUS MONONUCLEOSIS

Infectious mononucleosis may be followed by a syndrome which is identical to a major depressive episode. The diagnosis of infectious mononucleosis is made by a positive heterophile or mono spot test. A single negative test never excludes the diagnosis.

INFECTIOUS HEPATITIS

Mental and emotional symptoms before, during, or after infectious hepatitis of any type, A, B, or non-A non-B, can range **from mild lethargy to major depression.** There are even some reports of suicide and acute delusional mania following hepatitis.

MULTIPLE SCLEROSIS

Multiple sclerosis is a demyelineating neurologic disease characterized by lesions that are separated in space and time within the central nervous system. It has been associated with a wide variety of psychopathological symptomatology including mania and depression.

PANHYPOPITUITARISM

Psychiatric presentations are common in pituitary failure and usually present with **depression and lack of libido.**

POST CONCUSSION SYNDROME

The post concussion syndrome occurs as the after effects of brain damage from severe head injury. It may present as anxiety, depression, excess anger, loss of emotional control, mood swings from euphoria to depression, and social disinhibition. **Lesions of the left hemisphere, especially the left temporal lobe, tend to produce more intellectual deficits, whereas affective and behavioral symptoms are more frequently observed in right hemisphere damage.**

SYPHILIS (GENERAL PARESIS)

At one time, Syphilis accounted for 10-20% of all admissions to state hospitals for the insane. This makes penicillin one of the most important psychiatric treatments and the **VDRL and STS the most important psychiatric laboratory tests** of all time.

SYSTEMIC LUPUS ERYTHEMATOSUS

Systemic lupus erythematosus is a relatively uncommon disease that occurs in 2-3 per 100,000 population with a 9:1 ratio favoring females. It can present any time between ages 10 and 70 and may be accompanied with **a wide variety of psychiatric symptoms,** including mania, depression, schizophreniform or schizophrenic psychosis, and organic brain syndrome; it may even be labelled as a conversion disorder. **It is too often overlooked in young females presenting with emotional symptoms and complaining of arthralgias, despite the fact that arthralgias are the most common first presentation of this disorder.**

VITAMIN DEFICIENCIES

Among the better known vitamin deficiencies associated with mental and emotional symptoms are folate (Hall et al., 1981; Jefferson & Marshall, 1981), **and vitamin B12 deficiency** (Jefferson & Marshall, 1981), **as well as niacin (nicotine acid) deficiency. Folic acid deficiency presents with depression, fatigue, and lassitude.** Marked deficiency can present with burning feet, restless leg syndrome, and/or a depression that is unresponsive to antidepressant therapy. Coppen and Abou-Saleh (1982) found a higher rate of affective morbidity in those patients with low folate levels as compared with those patients with normal folate levels in patients treated in a lithium clinic. Hall and colleagues (1981), in a prospective study of hospitalized state psychiatric patients, found three cases of folate deficiency, two of which presented as RDC schizophrenia and one as RDC schizoaffective disorder. Normal CBC folate deficiency occurs frequently and is often misdiagnosed and mistreated.

Vitamin B¹² deficiency may also present psychopathologically in the absence of any signs of anemia or bone marrow changes. It may present neurologically as a peripheral neuropathy or myelopathy (subacute combined degeneration). It has been known to present with **a wide spectrum of mental and emotional disorders** including apathy, irritability, depression, dementia, confusional states, paranoid states, and schizophreniform psychosis (Jefferson & Marshall, 1981).

Patients who develop a zinc deficiency may become "frankly depressed," complain of lost interest in food, and show weight loss.

PHYSICAL ILLNESS PRESENTING AS PSYCHOPATHOLOGY

Depression symptoms caused by drug, alcohol, and other substance abuse appear to be the most common cause of psychiatric misdiagnosis and mistreatment. As a general category, endocrine disorders present most frequently associated with depressive symptoms. Provocative testing will make that point even more clearly in the future. The next most commonly involved organ system is the central nervous system. Toxic and withdrawal disorders were found third most commonly. Nutritional disorders and infectious diseases are the next most common. Cancer and metabolic disorders like Wilson's disease, acute intermittent porphyria, G6 PDase deficiency, and polycystic ovaries are found but are rare unless the client has an unusual presentation, recent treatment failure, atypical features, or 20 pounds or more weight loss.

SUMMARY

To reduce misdiagnosis and mistreatment of depression and other mental disorders, a complete physical, neurological, and endocrinological examination should be performed by a physician who is fluent in both psychiatry and internal medicine. This examination should be directed toward finding possible physical illnesses that can cause or exacerbate mental and emotional symptoms.

The laboratory is becoming an important component of any evaluation (Gold et al., 1982), but it does not replace the physician. Lab tests are ordered to correspond to and confirm the major issues in the differential, and they may reveal unsuspected diagnostic clues.

The mental health practice is likely to change radically in the future. We hope that the information contained in this lesson and reported elsewhere in greater detail (Gold, Lydiard & Carman, 1984) will help present and future mental health professionals to more easily make this change.

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QUESTIONS BASED ON THIS LESSON:

29. Which of the following statements is correct?

   A. If a patient has had a recent physical examination, the therapist can always rest assured that no physical illness is present or will show up in the near future

   B. In Hall's study of psychiatric outpatients, not one revealed a physical disorder producing psychopathologic symptoms

   C. In Hall's study of state hospital patients, 46% had previously unrecognized, undiagnosed physical illnesses specifically related to their mental and emotional symptoms

   D. When physical disease contributes to mental and emotional symptoms, the problem is never manifested as depression

30. In Koranyi's study, what percentage of nonpsychiatric physicians failed to diagnose physical illness in patients they referred to psychiatrists?

   A. 8%

   B. 17%

   C. 32%

   D. 48%

31. Which of the following statements is/are correct?

A. In Hall's study of state hospital patients, over half the patients with physical disease improved dramatically with regard to mental and emotional symptoms once the physical disorder was adequately treated

B. In Koranyi's study, only 12% of all patients referred for psychiatric care by social agencies or who were self-referred had undetected physical illness

C. If the first presentation of a client conforms closely to classical DSM-III descriptive criteria, it guarantees that he or she suffers only or primarily from a mental and emotional illness

D. Very few and highly specific forms of medical disease manifest themselves as depressive disorders

32. Which of the following statements is correct?

A. Sexual dysfunction, marital problems, and depression are rarely, if ever, seen inpatients with diabetes mellitus

B. Malignant tumors may present with depressive symptomatology months before any physical signs or symptoms appear

C. Mental and emotional symptoms have been noted in 98% of patients taking prescription medications on a regular basis

D. Cushing's Syndrome never presents as an affective illness

Directions in Mental Health Counseling

VOLUME 1 • LESSON 9

Understanding Shame

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EDITOR'S NOTE

I have long considered that the experience of falling apart emotionally and having to consult a mental health professional--much less be hospitalized for a psychiatric illness--must be a shameful experience for most clients. Invariably I have asked each client I have seen, at some appropriate moment early on in our contact with each other, whether he or she finds what they are going through humiliating, tearing painfully apart a cherished sense of pride and self-esteem. When the client is able to acknowledge such a feeling, express it, discover that I fully understand and appreciate it, that transaction has invariably led to a diminution in his or her suffering and a greater willingness to participate in therapy.

In this lesson, the author has defined the nature of shame and pointed out its enormous psychological power. Seemingly irrational anger, the refusal to communicate, an abhorrence toward therapy, noncompliance with medication regimens, and a host of other untoward behaviors are, in fact, commonly manifestations of shame. In fact, what Freud originally defined as "resistance"--the force with which the client avoids revelation--may be more rightly seen as shame; if so, a different psychotherapeutic stance to such moments may be called for and may well lead to more rapid and effective progress in any analytically based venture.

What I had never seriously thought of prior to reading this lesson was something so obvious that even I felt somewhat embarrassed that it had not occurred to me before: how can we therapists listen to all that clients tell us about the most intimate details of their lives and not be subject ourselves to countertransference responses that include our own sense of shame?

Introduction

There is a peculiar dichotomy in modern mental health theory and practice. On the one hand, classical psychoanalytic language describes all emotions as the phenomenology of anxiety or pleasure, both of which are seen in terms of drive theory and the concept of the discharge of psychic energy. Much contemporary research, on the other hand, groups symptoms and clinical observations by shared biochemical characteristics, such as neurotransmitter deficiency or endocrine dysfunction, and tends to ignore classical descriptors of emotion. Using the former logic, Anthony (1984) describes shame as "a separate developmental track for anxiety," whereas Quitkin et al. (1984) discuss clients whose "atypical depression" responds best to treatment with monoamine oxidase inhibitor antidepressants and whose symptoms include social phobia, rejection sensitivity, applause hunger, and lowered self-esteem. All those terms are better understood as manifestations of shame. In this lesson I will summarize current research and thinking about the emotional shame and suggest ways such understanding can be integrated into our therapeutic approach.

The Phenomenology of Shame

While it is true that each of us "knows" what it feels like to be embarrassed or to be humiliated, we do not know with any certainty what another person is trying to express when using those words. **Terms that imply the acute lowering of self-esteem include mortification (feeling shamed to death) as well as the less toxic experiences of being put down, ridiculed, or slighted. Shyness, bashfulness, and modesty are attitudinal sets chosen to avoid shame. Disgrace, dishonor, degradation, and debasement refer to complex social interactions involving some aspect of shame in which our relationship with another undergoes gross negative alteration.** Wurmser (1981), recognizing that each of us forms an intensely personal lexicon for shame, suggests we consider as cognates all the many words by which the shame experience is known; thus we speak of **the "shame family of emotions"** rather than any specific member. **It is essential that we ask each client to describe a shame experience in detail adequate for us to understand the importance of what is being discussed as well as the depths to which it must be studied.**

Wurmser (1981,1987) points out **shame follows a moment of exposure, and that such uncovering reveals aspects of the self that are peculiarly sensitive, intimate, and vulnerable in nature.** He summarizes the content of this complex emotion as follows: **"What one is ashamed for or about clusters around several issues: (1) I am weak, I am failing in competition; (2) I am dirty, messy, the content of my self is looked at with disdain and disgust; (3) I am defective, I have shortcomings in physical and mental makeup; (4) I have lost control over my body functions and/or my feelings; (5) I am sexually excited about suffering, degradation and distress; (6) watching and self-exposing are dangerous activities and may be punished."** In the adult, as Kaufman (1985) points out, **shame is often triggered by betrayal, treachery, or abandonment--anything that breaks the "interpersonal bridge."**

Listed above are some of the most difficult and painful emotional experiences ever faced by an adult. **How does shame come to have such power?** Is there a developmental line for shame along which experiences are accumulated, thus allowing the formation of so many complex adult emotion states that incorporate shame? Broucek (1982) comments that, **even in the infant, "there appears to be a clear relationship between joy, efficacy experience, and the formation of the sense**

of self. In a complementary way, inefficacy, if occurring in the context of the activation of any affect in the interest-joy-excitement group, may result in a primitive shame experience with a [consequent] disturbance in the sense of self." Our name for the emotion resulting from the happy confluence of the affects excitement or joy and the experience of personal efficacy is pride, which by its nature is always linked to the emotional shame in reciprocal fashion. The work of Stern (1985) and others suggests the sense of self begins to emerge in infancy; equally does it become clear that the emotions of self-evaluation must accompany self-development. **Pride and shame form an axis intimately related to the modulation of self-esteem.**

In the moment of shame we experience a cognitive shock, an instant during which we are unable to think clearly or plot effective action. Darwin (1979) saw that "confusion of mind" as a basic element in shame: "Persons in this condition lose their presence of mind, and utter singularly inappropriate remarks. They are often much distressed, stammer, and make awkward movements or strange grimaces." Elsewhere, I (1987) have suggested that much of the phenomenology of shame affect can be explained as the operation of a neurochemical vasodilator substance elaborated by subcortical affect centers and transmitted upward (both structurally and phylogenetically) to higher structures to cause this acute interference with higher thought processes; extracranial "leakage" of such a substance might account for the blush. I have delineated in great detail a "timetable for shame" to suggest the chronology for the assembly of that hypothesized neurochemical affect mechanism with accumulated experience, forming the layers of shame emotion described by clinicians. Such work may be considered an extension of the affect theory of Tomkins (1962, 1963, 1982, 1987) that lies at the core of the contemporary reevaluation of the nature of emotion.

Whatever turns out to be the correct schema for the biology of shame, when humiliated we wish for the earth to open and swallow us; we feel shorn not just from the other before whom we have been shamed, but from all humanity. Like shame, guilt is an unpleasant emotion experienced as if it were directed by one agency of the self against another. Where guilt refers to internal punishment for wrongdoing, for violation of some rule or law (internal or external), shame is about some quality of the self. **Guilt implies action, whereas shame implies some quality of the self has been brought into a question. Wrongdoing involves guilt; unwarranted opinions about the self, once exposed, will produce shame. With experience comes the ability to predict the effects of our actions. Therefore, guilt limits action and shame limits narcissism.**

Lewis (1981, 1987) believes the inherent function of both shame and guilt is to modulate social interaction. In her system, guilt provides a signal that we are ready to accept the rules of society, whereas the blush informs the shaming other that we have renounced a socially unacceptable view of ourselves and wish to be returned to the group. It was she who introduced the term "humiliation fury" to describe the rage expressed by one for whom the experience of shame is not mitigated by a sense of security (Lewis, 1971). The reduction in self-esteem and in the esteem of others and the confusion associated with shame can be so toxic for the individual that only anger and the frightened response of others can return the preexisting sense of competence. Lansky (1987), Scheff (1987), and Retzinger (1987) have written extensively about the importance of this link between shame and anger to normal and pathological interpersonal interaction.

Laughter, too, bears a significant relationship to shame. Take paper and pencil in hand while watching the work of any comedian, or any televised situation comedy, and note the frequency with which shame takes center stage. **Jokes are less about hostility than about embarrassment**. Freud's (1961) drive-based psychology forced him to describe shame and guilt as if they represented hostility against the self that stemmed from the aggression drive; the laughter associated with embarrassment, which seems to account for a large portion of what we find "funny" or "amusing," was misunderstood by him as a function of hostility. **Generations of clients have been insulted by mental health workers who labeled their humor as angry when it might more accurately have been described as an attempt to deal with self-related conflicts couched in the language of embarrassment.** Scheff (1987) and Retzinger (1987) note **clients can be taught the skills of humorous self-effacement, for by focusing our laughter on ourselves, we reduce the potential for noxious interpersonal anger.**

Wurmser (1981) comments that **at the core of the adult experience of shame is the feeling that one is unlovable,** that intrinsic to the moment of confusion and isolation we known as shame is the thought that that feeling of interpersonal rejection is deserved. Morrison (1983, 1987) uses the language of self psychology to explain that **during moments of maternal empathic failure, the child really does feel unloved. Shame and empathy are mutually exclusive states--each will interfere with or turn off the other.** Shame, therefore, may be defined in terms of such a significant loss of empathic contact (the loss of normal self-object mirroring) and thus figures into the child's concept of love and lovability. He suggests the degree to which an individual is hurt by a shaming interaction is directly proportional to the significance to that person of prior experiences of empathic failure.

The Ubiquity of Shame

The definitions of shame offered above allow us to see the emotion of hiding, withdrawal, and "inappropriate anger" in situations where we might once have ignored it. Following is a group of anecdotes culled from a single day's observation.

- From the local newspaper I learned that, on **leaving the locker room after his high school team lost a state championship game, an enraged football player had run head first into a wall.** At the time the story appeared, he had been comatose for days, and it seemed he would survive with the sequelae of quadriplegia and vastly reduced cortical function. Using traditional therapy language we might say that the young man became angry because he felt "frustrated." But other explanations are much closer to our day-to-day experience--we can understand winning a championship game as an event that might define a higher level self and give one a better sense of self-esteem. **Winning moves one upward on the shame/pride axis. I suspect for that young athlete, winning a championship game had promised a lift in self-esteem made supremely important by some previous series of events that had reduced his sense of self-worth.** The seriousness of the issues involved may only be deduced by reference to his deadly reaction to failure. I remember a much-respected professor telling us residents he felt suicide was a reasonable alternative for a disgraced national leader. He, too, was commenting on the morbid side of shame.

- In a supermarket, I watched a mother loudly berate her four-year-old boy, calling attention to his behavior for all to witness. He stood there, apparently defiant, but with his head slightly to one side, eyes averted from his mother's face. **Shame affect,**

the primitive aspect of shame seen even in the neonate, involves some sort of gaze aversion--usually accompanied by loss of tonus in the neck muscles and consequent drooping of the head and shoulders.

- My suburban newspaper reported a local organization had received an anonymous bequest of $10,000. Schneider (1987) remarks that just as exposure leads to embarrassment, we may say privacy involves protection from exposure. **Thus it may be said that shame teaches privacy.** Anonymity protects the privacy of the donor and focuses attention on the recipient.

- Neighbors called me to ask advice. For some hours **their 15-year-old daughter had withdrawn in tears to her room, refusing contact with them or anybody.** All they could offer as a precipitating event was that immediately before her uncharacteristically unsocial action, **she had learned that her best friend told a classmate she liked him.** We may guess the secret thrill of adolescent affection may be made more tolerable by discussion with an intimate and trusted friend but leakage of such terribly private information about the self will be experienced as betrayal and, hence, trigger shame.

- A modishly slim, sophisticated 35-year-old lawyer opened a therapy session by commenting she had spent the morning running frantically through her wardrobe, dissatisfied with every garment she tried on. "I was having a fat attack," she said. "I looked fat in everything I put on my body." Recalling Wurmser's advice that shame is a layered emotion and prime among the cognitions accompanying shame are thoughts of ourselves as defective, ugly, or worthy only of rejection, I interpreted her discomfort as shame and suggested we look for a precipitant. Speedily she identified a dream that portended a humiliating encounter with a senior colleague. **Behind that dream**

we found a long history of humiliations by her contemptuous father. Given that background, which caused her to equate personal competence with her identity as a lovable person, it was now understandable that she might handle this anticipated humiliation at the level of body image, where she really felt much more secure. While it is true that many people "work out" in an attempt to achieve aerobic fitness as part of their overall approach to health maintenance, a much larger number of people use physical fitness to shore up a self-image that sags for nonphysical reasons. **Therapists and counselors skilled in the handling of shame-related problems will always be aware that the thoughts accompanying an episode of shame will rarely reflect the layer of shame at which the emotion was triggered.**

- A 55-year-old lawyer mentioned the worst experience of his first day at work after graduation from law school. Seated proudly behind his desk, some few minutes after taking possession of his new office, he was greeted by a senior partner, who poked his head in the door and said, "Why Mr. S--. You seem to have forgotten your hat today." At lunch the young lawyer purchased his first hat. Shame operates to make us feel shorn from the herd, isolated, and unworthy; thus, shame powers conformity. Wherever we see a client seemingly driven to conform to social norms or to be accepted by "society," we can suspect activity along the shame/pride axis.

- A friend in another city called to ask advice. The busy couple, both occupied nearly full time with their careers, had left their children, two girls, ages three and seven -- in the care of a trusted woman who had become like part of their own family. their fears. **It seemed that the woman would leave the children in the company of her 13-year-old son, who had made sexual advances towards them. When**

this behavior was revealed to him by his eldest daughter he was furious. Through his rage and grief, my old friend asked, "Why did it take so long for the girls to tell us? Didn't [the boy] understand what would happen to him when people found out? Everywhere I look there are secrets." We discussed the relationship between secrecy and shame, and the delicacy with which these disclosures would have to be treated. **As mandated by law, the involved therapists would have to report the behavior to the police. Shame would be unavoidable, as it would be in any case of abuse or exploitation, and was a feeling that had to be faced and managed (Nathanson, in press).**

Shame in Psychosis and Borderline Illness

Drawing from his lifetime study of clients with **schizophrenic psychosis**, Will (1987) notes the frequency with which shame-based conflict appears in their treatment. He cites, among other **prominent concerns, "A long-standing (often privately maintained) sense of estrangement from the world of others"; "The absence of an intimate, trusting relationship with another person"; and "An increasing sense of isolation and social failure, emphasized by the many socializing demands of adolescence, threatening to a fragile self-esteem."** He continues: "The psychotic state is not a bed of roses (or a rose garden) but then, neither is reality.... Some aspects of the dreaded 'reality' are (that)...**to be, or to have been, psychotic is to be 'different'; one has been labelled.** Having lost control of one's very self in the exposure of terrors previously, at least partly, hidden and dissociated--having 'gone crazy'--it is difficult not to feel less than human. There comes **a recognition of being a member of a group of people that as a whole is feared and unwanted,** and in some instances has been done away with in the practice of triage." Nowhere in the work of those who celebrate the positive benefits to be achieved from or during psychosis do I find any mention of shame or any understanding of madness as stigma.

Just as shame usually is ignored in the study and treatment of psychosis, those sensitive to the phenomenology and psychology of shame are struck by **the nearly complete absence of reference to shame in most work on "borderline illness." Reading Kernberg's classic paper (1975) defining "splitting of the ego" in the borderline client, I find each and every example of "splitting" little more than a description of the normal operation of shame affect.** It may no longer be possible to accept Kernberg's statement that "this state of affairs represents an ego weakness...a most rigid kind of structure... the alternating activation of contradictory ego states might...reflect a specific defensive organization, perhaps characteristic of borderline patients."

Even a cursory rereading of that paper and a myriad of others that discuss "borderline personality organization" must raise serious objections to the astonishing regularity with which shame has been overlooked in contemporary mental health theory and practice. Kernberg (1986) later comments "narcissistic personalities" show an "unusual degree of self-reference in their interaction with other people; a great need to be admired by others and a curious apparent contradiction between a very inflated concept of themselves and an inordinate need of tribute from others." As Lewis (1987) suggests, the **"contradiction between an 'inflated' self-concept and a self that needs reassurance of its worth becomes less 'curious' if we assume that what is being described is the operation of shame."** Like most of the gifted therapists and theorists who have focused on the importance of shame, she sees "narcissistic personality" and "narcissistic illness" as wastebasket terms that protect outmoded concepts at the expense of the client. Wurmser (1981) calls narcissism a "rubber concept," a term that has been stretched so far as to lose meaning for most of us.

Discussion

That shame and pride are little discussed in therapy is puzzling. **Whenever two people agree to discuss what is personal, private, and hidden, they skirt the edges of shame.** In our culture, the model for all psychotherapeutic disclosure is that of psychoanalysis, devised by Freud as a method of research allowing disclosure within the privacy of a special form of healing relationship. Anthony (1984), however, calls psychoanalysis "an arena of shame" within which each disclosure must trigger embarrassment. It is as if analytic uncovering removes not just the layer of defense that maintains certain thoughts, memories, or fantasies in their hidden state but also releases the affect of shame locked in during the process of camouflage. What is most peculiar--and indeed what has impelled the recent upsurge of interest in shame itself--is that until recently no readily available body of knowledge within the mental health field has allowed competent understanding of shame and competent treatment of shame-based psychopathology. Therapists who themselves have not been treated and trained in the area of shame cannot treat shame.

Perhaps the fault lies not in any intent of the founders of psychoanalysis, but in an error inherent to analytic theory and technique. Freud (1914) decided early that the human is animated or driven by forces that operate largely out of conscious awareness. His early experiences in the treatment of hysterical illness convinced him that primary among those driving forces was libido, the push of the organism to reproduce itself and maintain the species. When libido was expressed as the urge toward sexual congress, the organism fared well. Where libido could not gain expression, those drive energies were handled in aberrant forms called neurosis. In order to relieve the symptoms of neurosis and allow libido energy egress through proper channels, Freud encouraged his analysands to tell him everything that occurred to them, to disclose their thoughts at every possible level of importance. Of course, he was especially interested in thoughts and feelings around the issue of sexuality, notwithstanding the fact that such mental contents must normally being with them significant amounts of embarrassment.

Since it was embarrassment that prevented the disclosure of the sexual secrets Freud wanted to learn, he devised a strategy to disarm this particular defense. Had he approached the problem by launching an intensive program of research into the nature of shame, the history of our field might have been significantly different. For better or worse, he maintained strict focus on libido, which remained his core interest, and **he prevented any serious inquiry into the nature of shame by defining it as "resistance."** Thereafter, any reticence demonstrated by a client, any impediment to the disclosure of sexual material, was demeaned as "the resistance" and treated with disdain. Shame, the far more powerful emotion, was relegated to a place in psychoanalytic lore much lesser than guilt. Centuries of experience with confession had taught the Catholic Church that guilt can be relieved quite simply by forgiveness and absolution. Shame, however, wounds far more deeply than guilt, and cannot be undone by such simple methods. By choosing to base psychoanalytic technique on the phenomenology of guilt and fostering a system of treatment that ignored shame, Freud found the easy solution to a problem only now emerging as a central issue in all therapy.

Stoller (1987), perhaps the most intrepid and successful psychoanalytic investigator of adult sexuality in this era, remarks, "I have about reached the point where any clinical narrative is incomplete that does not either mention the humiliation at its core or that humiliation was looked for and not found." He continues, "I am uneasy when colleagues say 'resistance,' or 'the resistance' as if they believe in a special force with roots deep in mystery (e.g. 'narcissism,' 'repetition compulsion'). **Most resistance, to me, is simply a person's awareness--conscious, preconscious, and unconscious--of fearing feeling humiliated." What people fantasize during sexual excitement, finds Stoller, are scenes in which they attempt to recover from a lifetime of humiliation**--to triumph (by sexual success in the current, external world) over the shaming other now residing within them.

Once shown the ubiquity of shame conflict, the amount of shame-related pain experienced by our clients and **the ease with which such pain may be relieved by modest alterations in therapeutic technique**, most therapists embrace this new work without concern for the implications for psychoanalytic theory noted above. **Where once we might have seen as resistant the silent client (who refuses eye contact and seemingly undermines the therapeutic contract by remaining obdurate despite our instruction to tell all), now we can spot the stigmata of shame, understand those forms of silence as precise communications about the underlying feeling-state of shame, and move swiftly to handle it within our own therapeutic style or system.**

Similarly, as I have indicated at length elsewhere (1987), **understanding shame lets us become more sophisticated in our use of medication in the management of affective illness.** Just as the agitation or somnolence of depressed clients may lead to the choice of quite different medications, the assessment of guilt and shame may lend similar discriminative power. **Clients whose expressed symptoms are canted more in favor of guilt seem to do better with the older class of tricyclic antidepressants. Those who describe their symptoms in terms of personal defect, problems of social interaction, and the need for efficacy experiences that push them toward pride and away from chronic shame frequently seem to require the monoamine oxidase inhibitor class of antidepressants. Often it seems "refractory" or "atypical" depression is shame-loaded depression.** I am encouraged by my recent experience with fluoxetine in that group of clients but cannot as yet recommend it with equal enthusiasm. **Note, too, that clients who urge us constantly to let them "get off" their medication, who feel stigmatized by the requirement for chronic medication, are often dealing with unanalyzed shame conflict.** Even bipolar clients are more compliant when shame issues are discussed.

Finally, it must be recognized that we are in the early beginnings of the biochemical investigation of psychological function. Just as I have suggested a neurochemistry for shame, I suspect specific disorders of affect physiology result in alteration of the experience of shame. Even "depression" has become a wastebasket term for a broad group of dysphorias, many of which are peculiarly bound to the psychology of shame. Future research may concentrate on the relationship between the biological mechanisms responsible for the production of normal affect, the alternations in normal biology responsible for many psychopathological conditions, and the ways those variant physiologies may affect human development and interpersonal relatedness. It is the hope of all of us who study shame that our clients may benefit from this new attention to the affects in general--and specifically to what has been for so long the ignored emotion.

Some Suggestions for the Psychotherapist

Learn the variety of ways shame can be expressed. **Because the layering of experience that turns each innate affect into a mature emotion is so complex, we never really know what another person means when using an emotion label. The initial phases of all psychotherapeutic interaction allow the therapist and client to develop a lexicon of emotion,** to learn what each means when using the common words for emotions. Some people handle shame by withdrawal, some by anger, some by humor (accounting for the genre of anecdotes called "my most embarrassing experience"), and others by stone-faced refusal to emote.

Remember, **shame attends both the one who has been uncovered and the one who uncovers. We can be as embarrassed by what we learn in our role of therapist as the client who describes the shaming scene to us.**

Once you have decided that the client is experiencing this complex emotion, try to **determine what triggered it by the methods of analysis described above.**

Learn how the client has defended against prior experiences of shame. Be careful not to expect him or her to use your system no matter what it is or how successful it has been for you in the past.

Support the client's own expression of embarrassment, whether in the form of anger, laughter, withdrawal, or tears. Only after you understand that person's characteristic mode of defense against shame can you mobilize the defensive system you believe is more therapeutic.

When severe shame-based psychopathology--especially as seen in atypical depression--fails to respond to psychotherapy based on the new understanding of shame as affect and emotion, consider a trial of MAOI antidepressants or fluoxetine.

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QUESTIONS BASED ON THIS LESSON:

33. Which of the following statements about shame is correct?

    A. Laughter always relates to hostile feelings and has nothing to do with shame

    B. At the core of shame is the feeling of being unlovable and hence suffering deserved rejection

    C. Shame and empathy are partners, each reinforcing the strength of the other

    D. Shame has more to do with a sense of having done wrong than one's estimate of self-esteem

34. Which of the following statements about shame is/are correct?

    A. Kernberg's classic definition of "splitting of the ego" in the borderline individual may well only describe the normal operation of shame affect

    B. Freud may well have prevented a serious appreciation of and investigation into the powerful role of shame in behavior by defining clients' reluctance to reveal as exclusively resistance

    C. By spotting the behavioral signs of shame and enabling clients to acknowl edge the experience in an empathic setting, the progress of psychotherapy can be enormously enhanced

    D. All of the above

35. Which of the following is not commonly associated with the experience of shame?

A. Being weak and failing in competition

B. Being dirty, messy, and looked at with disdain and disgust

C. Being physically or mentally defective

D. Being able to recognize, manage, and appropriately express emotions

36. Which of the following statements about shame is/are correct?

A. While it is important to discuss the client's experiences of shame, the therapist need never be concerned that he or she will feel any shame as the one listening to the revelation of emotional secrets

B. Clients should feel ashamed of their mental conditions, since they are different from others and must accept that fact sooner or later

C. Initially one should support the client's usual way of handling shame, whether in the form of anger, laughter, or withdrawal, only later enabling him to find a better way of managing it

D. Shame is so painful that it is best to ignore it entirely in psychotherapy, particularly since it can undermine the client's motivation to remain in therapy

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The Psychotherapy of Depression

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EDITOR'S NOTE

Loss is an important trigger for depression. So is personality vulnerability, with both developmental and genetic contributants. Certain personality traits, such as lack of self-confidence and self-assertion, can appear in childhood and persist to characterize adults with depression-prone personalities. Such individuals are somewhat timid and excessively sensitive to disapproval; they often retreat from challenges and problems; they usually repress aggression, tending to turn it inwardly against themselves; they appear to have low self-esteem--regardless of accomplishments--and persistently depend on others to provide love, recognition, and reassurance.

Contemporary environmental factors also contribute to clinical depression. Particularly vulnerable are women without other adults in whom to confide, those at home with three or more children under the age of 14, those in poor living and housing conditions, and women who have lost mothers prior to the age 11.

Psychotherapy has certain goals: to help the client make sense of his or her disorder; to clarify the meaning of life events from earliest memories onward; to demonstrate how present difficulties relate to lifelong adaptational problems. Therapists and counselors can help clients change, through insight, those problems that can be changed within themselves and to live more effectively with those that cannot by understanding and dealing with--or avoiding--social factors that aggravate their vulnerability to depression.

The depressed individual is often compliant in therapy. One must keep in mind the importance of exposing aggressive impulses, but do so in a way that will not threaten the therapeutic relationship. Do not take the readily formed positive transference at face value; it is often motivated by fear more than affection. Use rapport and transference to help the depressive cultivate a better sense of his or her own worth.

Introduction

Depression is probably the most common symptom for which people seek help from mental health professionals. As every psychotherapist knows, **depression varies in severity from a transient, trivial diminution in vitality to a profound, psychotic state of melancholia in which the client is deluded and inaccessible.** Since the advent of electroplexy, of effective antidepressant drugs, and of lithium, there has been an unfortunate tendency among psychiatrists in particular to treat episodes of depression by using these relatively simple physical methods without seeking psychodynamic explanations for the condition or offering any form of psychotherapy. In this lesson, I shall try to demonstrate the important part that psychotherapy plays in the treatment of even the most severe cases of recurrent depression.

The Depressive Personality

Every human being is susceptible to depression as a consequence of bereavement, disappointment, or failure. The loss of a loved one provokes--and is expected to provoke--depression in the most robust of us. Disappointments in love or discouragement at being passed over for a sought-after position are common precipitants of depression in many people. Failure to pass an examination is a frequent cause of depression in young people, as is failure in business in older individuals. **What these different precipitants have in common is that they all involve the loss of something or someone in which the individual concerned had invested emotional energy and which were therefore bound up with his or her self-esteem. The rate at which a person recovers from the depression induced by these commonplace hazards of ordinary life varies with the severity of the loss itself.** It is my impression that today, when most children in Western society can be expected to survive and flourish as adults, the **loss of a dearly loved child is**

one of the worst bereavements that anyone can suffer. The depression induced by such a loss may, even in normal people, be prolonged for two or more years, and there is a sense in which some parents may never wholly recover from such a loss.

However, **the severity of the loss experienced is not the only factor concerned** in either the profundity or the duration of these so-called "reactive" depressions. **Differences in personality are equally important.** Some people become much more easily depressed than others in response to what may appear to be trivial precipitants. In such cases, the depth and duration of the depression are also often excessive. For example, a man or woman may become suicidally depressed after what appears to be no more than a passing dispute with a spouse. We designate such people *depressive personalities*.

Endogenous versus Reactive Depression

The notion of an exclusively endogenous depression--that is, depression coming on for no discernible reason whatsoever--should, I think, be dropped. The word "endogenous" is simply a cloak of ignorance. The more one investigates cases of depression, the more likely one is to discover the trigger that provoked a particular episode. Brown and Harris (1978) recorded a number of people with depression whose illness did not appear, at first sight, to have been provoked by major difficulties in life or severe life events. **However, further investigation of these cases revealed that many of the women had in fact been exposed to traumas of a kind that did not come within the categories laid down by the researchers.** For example, one woman had to leave her job because of rheumatoid arthritis that, she had been told, was incurable--a life event that might be expected to provoke depression in most people. Another had become depressed upon hearing that a male co-worker on whom she had a crush was already married. **Patients themselves are not always able easily to identify what factors initiated a particular attack, and this is one reason why a psychotherapeutic investigation is needed.** As they begin to understand themselves better during the course of psychotherapy, they begin to recognize their vulnerabilities and understand the emotional precipitants of depression. Very often, a tactless or unfeeling remark on the part of someone close to the person--one that is perceived as damaging to self-esteem--may cause him or her to feel disregarded, unloved, despised, or rejected. He may have repressed the incident only to have it recalled during the course of psychotherapy. In such instances, **the depressive person may despise himself or herself for such sensitivity and add to depression by feelings of having overreacted in this way,** that any "normal" person would not be so foolish. I do not believe that even the severest attacks of depression come on spontaneously without any external precipitating cause. **This is not to deny that genetic factors, biological periodicity, and other internal factors may be equally important,** but simply to affirm that some kind of trigger is necessary for the depressive reaction to occur.

It is worth noting that, during the last 50 years, more and more illnesses and abnormalities that were alleged to be the consequence of built-in flaws in the individual have been shown to be caused by external agents. For example, the defects now known to be caused by maternal rubella were thought to be inborn defects. Many forms of cancer, most notably cancer of the lung, are the consequence of noxious agents only recently identified. The importance of dietary fiber in the prevention of diseases of the bowel has only been demonstrated within the past few years. **The fact that severe stress of the kind experienced by prisoners of war and concentration camp victims can cause both physical and mental illness that**

may not appear until many years after the stress is relieved was only fully realized when research conducted after World War II revealed it to be so. The more we learn about both mental and physical disorders, the more we find that previously unrecognized external factors are important causal agents. Until I am proved wrong, I shall continue to believe that both severe and mild depressive reactions require some external stimulus of a noxious kind to provoke them.

Vulnerability of the Depressive Personality

Why are some people precipitated into profound depression by external stimuli from which the normal person will soon recover, shrug off, or disregard? The answer to this question cannot be given either completely or with certainty. **That genetic factors play a part is almost certain.** According to Kagan (1984), temperamental differences between infants can be demonstrated from the earliest days after birth. What Kagan calls "inhibition to the unfamiliar" can be demonstrated as early as eight months, and tends to persist throughout childhood. **Inhibited children are restrained, watchful, and gentle. If a stranger appears, they stop playing and observe the stranger warily. They tend to have more nightmares and unusual fears than uninhibited children, and are usually passive if attacked by another child. Because they are highly sensitive to reprimands, they tend to be unusually obedient and compliant. Inhibited children show more marked physiological reactions to stress.** Thus, they are more susceptible to allergic reactions and to constipation. Inhibited boys, when they become adolescents, tend to avoid traditional masculine sexual activities, to choose less masculine vocations in adulthood, and remain introverted and anxious in new social situations.

A number of these temperamental traits are rather characteristic of adults with depressive personalities. Because they appear so early in the child's life, they are more likely to be part of his or her inheritance rather than the result of faulty rearing, although I am not disputing that the infant's earliest experiences may be of importance. People who are particularly prone to depression and who do not habitually employ "manic defenses" **tend to be uncertain of themselves, overcompliant, and extremely sensitive to real or imagined disapproval or aggression from others. Like the inhibited children, they tend to retreat from new situations or problems, rather than attack them. Because they are so sensitive to disapproval, they dare not "stand up" to other people and tend to get pushed around by them.** This masochistic-like stance toward others means that **such people repress their own aggression.** They dare not show aggression to those who are close to them for fear of incurring further disapproval and loss of love. This is probably the origin of the well-recognized fact that, during an attack of depression, **the sufferer tends to turn his or her aggression inward against the self,** to reproach himself or herself for all past sins, and to declare that the illness is entirely his or her own fault.

As Freud (1957) pointed out in his classic paper, "Mourning and Melancholia," the reproaches that the depressed person levels at himself or herself are usually explicable as reproaches that he or she would like to have directed at someone close, but which he or she dared not express for fear of antagonizing someone upon whose love he or she is dependent.

To be so sensitive to disapproval argues that the person who is prone to depression has little or no built-in self-esteem. Those who are particularly liable to overreact to comparatively minor failures or losses by being plunged into profound and long-lasting depression seem to lack any inner resources to turn to in the face of misfortune. For them, failure in an examination or rejection by a possible sexual partner precipitates feelings of total hopelessness. Such people behave as though they believe there are no second chances in life, as though they were completely dependent for maintaining their self-esteem upon the success of whatever enterprise they happened to be temporarily engaged in, without taking into account past successes or future possibilities. **It is as if any love or recognition that they had had in the past counted for nothing, as if there was nothing inside themselves to which to turn, no sense of being intrinsically worthwhile.** It is worth recalling that many psychotically depressed people complain there is a void inside them, an emptiness that can never be filled. This apparently delusional statement is in fact a symbolic one, a metaphor expressing a psychological truth.

Although, in our present state of knowledge it is difficult to prove, **I think it reasonable to assume that the normal child who is welcomed, loved, and recurrently made much of, gains a sense of his or her own worth from these repeated experiences. This sense of worth becomes so much a part of the self that even shattering failures and losses do not leave him or her with a feeling of worthlessness.**

I am suggesting that Kagan's inhibited infants may be those who later become depressive personalities, and that, however much they may in fact be loved by their mothers during their first few years of life, they lack the ability to incorporate that love, to make it part of their inner worlds. They therefore fail to develop the kind of self-esteem that will see them through reverses in life without experiencing intolerable depression. We do not know enough about either psychology, physiology, or genetics even to suggest what this defect is, or how it is mediated.

What is clear is that those with depressive personalities remain dependent upon external sources for maintaining self-esteem. Like drug addicts, they require recurrent "fixes" to keep them on an even keel. The "fixes" which they demand are not drugs, but reassurances that they are loved and are successful in the external world.

Social Reasons for Vulnerability to Depression

In recent years, Brown and his colleagues have demonstrated that there are also social factors that determine a person's vulnerability to severe depression following loss. **Thus, women who have no other adult in whom they can confide are more prone to clinically definable depression. So are women who have at home with them three or more children under the age of 14. Lack of any job outside the home (which clearly often goes hand in hand with having small children at home) is another factor, and so is poor housing.** Knowing that these social factors affect whether a person's reaction to loss is "normal" or turns into a case of depression requiring psychiatric intervention is clearly important in deciding treatment.

Brown also discovered that those **women who had lost their mothers before they had reached the age of 11 were more vulnerable to depression in the wake of traumatic life events.** This is a particularly interesting finding that requires explanation. **Psychoanalysts have so emphasized the importance of early**

childhood in determining character that psychotherapists and psychotheorists have tended to underestimate the significance of later events. If it is confirmed that loss of the mother at as late as 10 years of age renders a person more liable to react to subsequent losses with severe depression, it follows that the child's character is not as clearly defined by the age of five as psychoanalytic theory suggests.

It also raises the question of whether subsequent losses somehow trigger a similar reaction to earlier losses. Loss of the mother is usually a significant loss in anyone's life, and it may be presumed to be more significant the earlier it occurs. **Do subsequent losses inevitably take on the quality of that most significant loss, even when they are not directly connected with it?**

Clinical experience suggests this to be so. Repeated traumatic experiences of any kind in a person's life tend to recall earlier ones and to be treated as more similar than is often the case. Every therapist and counselor must have seen women who complain that men always let them down, or men who make the same accusation about women. Although each instance of rejection or hurt may in fact occur for different reasons, they all tend to be gathered together under the same emotional umbrella. This means that even trivial instances of supposed rejection may be treated as if they were much more serious than they are.

One reason why a person may be plunged into severe depression by a loss which seems comparatively trivial is, therefore, that the trivial loss awakens echoes of a previous loss that was highly significant. Brown writes, "There may in depression be some kind of 'induced sensitivity' that makes subsequent episodes more likely...."

Psychotherapy of the Depressive Personality

Persons in the midst of a severe episode of depression are often beyond the reach of formal psychotherapy whilst the episode lasts. There is little point in attempting formal psychotherapy with persons who are suffering from a depressive illness when they are retarded or are expressing either hypochondriacal delusions or delusions of total worthlessness. Some clients in this condition actually repudiate any attempt to contact them, appearing to prefer to be left alone in their misery. **However, others are grateful for being listened to,** even if they are convinced that they have committed the unforgivable sin and are condemned to eternal punishment. **Because we now have effective physical methods of treatment for severe depression, we are apt to underestimate the importance of talking to, and listening to, psychotic clients.** The fact that a mental health professional is prepared to take what they say seriously is important to many deluded patients, who will often express their gratitude for this when they have recovered from the psychotic episode. **But the period between attacks of depression is, of course, the time when more formal psychotherapy can be most effective.**

The Aims of Psychological Therapy with Depressive Individuals

One aim of psychotherapy with any person is **to make sense out of his or her disorder.** In order to do this, **the counselor or therapist must become familiar with the patient or client's history and development from his or her earliest memories onward.** Every person in psychotherapy needs to be furnished with a coherent narrative of his or her life in order to make his or her personality and disorder comprehensible. Various psychotherapeutic "schools" may emphasize different factors as being of particular importance in causing the person to have become the way he or she is. Some analysts might postulate that the way the person was handled during the first few months of life was all-important; others may lay greater stress upon later periods. In our present state of knowledge, we cannot accurately determine how much the liability to depression is to be attributed to nature and how much to nurture. **What is important is that the characteristics of the depressive personality are usually manifested early, and that the person's emotional development and interaction with other people is generally fairly consistent.** For example, the depressed individual's fear of showing aggression to those upon whom he or she is emotionally dependent usually manifests itself early in life. Following upon this, it is usually not difficult to demonstrate a more general inhibition of aggression of such a kind that the person has lacked independent initiative, and has perhaps been inclined to give up too easily in the face of tasks or problems. As Seligman (1975) has demonstrated, learned helplessness goes hand in hand with depression.

Demonstrating to the depressed person that his or her present difficulties are related to the way in which he or she has developed as a person since childhood is only a first step in psychotherapy, but it is an important one. By gaining insight into the structure of his or her own personality, the person comes to feel that, however unhappy life may be at times, it at least makes sense in terms of his or her history and personality.

Armed with the knowledge of the importance of social factors in increasing vulnerability to depression, therapists should make the effort to become aware of such factors as they operate in persons under their care. Although no therapist or counselor can provide new housing, enough money to pay for child care, or a new spouse, the therapist's awareness of how a lack of these amenities contributes to the depth and prolongation of depression will influence how he or she responds to the various subjects of his or her client's discourse. It is only when one knows what to look for that one picks up what is important. Many depressed people blame themselves so severely for what they consider "weakness" that they do not realize normal people also react to adverse social circumstances with depression, and are often relieved when this is pointed out.

Insight into Vulnerability

As the depressed individual gradually becomes more aware of his or her own vulnerability through therapy, this vulnerability becomes somewhat modified. **Insight may not abolish emotional overreaction, but it does enable people to take a more detached attitude.** Instead of being overwhelmed by the emotion of the moment, her or she is, as it were, able to stand back and observe his or her own emotions--perhaps with regret, perhaps with a certain wry humor. "There I go again!" is a healthier attitude than, "This is the end of the world."

Moreover, **insight into vulnerability may enable depressed people to avoid certain situations that provoke depression.** For example, the punitive superego so characteristic of such a person may compel a woman to visit her cantankerous, elderly mother in spite of the fact that every visit is followed by severe depression. When the connection has been established, it may be that she can decrease the frequency of her visits without too much guilt, or even come to regard them as disagreeable chores rather than daughterly duties that she feels she ought to enjoy, but actually hates.

It is difficult, but not impossible, for the depressive person to learn that episodes of depression are always transient. **Most people who are at all seriously depressed believe that they will never recover from a particular attack.** Moreover, they often feel that being depressed is in some sense a more authentic condition than feeling cheerful or "normal." In this way they may be partially right, especially if they belong to that group of depressives who habitually try to ward off depression by overwork or other defensive maneuvers. **Some people have to come to terms with the fact that they are chronically depressed, and that a large part of their life is a struggle against this condition. The more they can admit this, the less are they overwhelmed with depression when, episodically, it becomes worse.** Depression resembles other episodic complaints like asthma. When the person is well, he or she tends to deny the disability and is therefore less prepared for the recurrence of an attack and less inclined to take precautionary measures to deal with it. I am sure that it is wrong to tell patients to "forget all about it" once an attack of depression is over, or say, "You may never get another attack." It is preferable to treat the liability to depression as a disability with which the person must come to terms, just as he or she might have to come to terms with being an asthmatic or an alcoholic. In all these conditions, people must learn to live with something that they would much rather be without but which cannot entirely be eliminated.

It is only when depressed individuals learn to accept their susceptibility to depression that they can also accept the fact that episodes of severe depression invariably come to an end. It is those who deny the possibility of further attack who are overwhelmed by the attack when it does come and who cannot believe that it will ever be over. Denial is a mechanism of defense that is both dangerous and ineffective.

Transference in the Psychotherapy of Depression

Depressive people of the kind I have been writing about are often labelled "good" because of their tendency toward compliance. Their anxiety to please the therapist and their capacity for repressing aggression often makes them appear to be nice indeed. One very important positive gain that can be achieved in psychotherapy is the realization that **the expression of aggressive feelings need not necessarily bring about the end of a relationship.** If therapists manage to bring to the surface the aggressive impulses that are buried within every depressive, to aid their expression toward them, and to prove by continuing understanding and compassion that they are still concerned and ready to help, they will be providing a learning experience for their patients that may well prove invaluable.

One useful opportunity for exposing aggressive impulses recurs in every period of counselling or psychotherapy of any length. I am referring to the times when therapy is interrupted by the therapist's vacation. On the therapist's return, the client will usually say that he or she has been more depressed or has suffered in other ways. It is generally possible to demonstrate that aggressive feelings have been felt toward the therapist for abandoning him or her, and also to show that the expression of such aggressive feelings is not a serious threat to the relationship.

Depressive individuals appear to form positive transferences very easily. It is important not to take this entirely at face value. When suspiciousness or hostility are apparent early on, analysis of their negative transference feelings is essential if therapy is to proceed. **In the case of depressive individuals, what**

appear to be positive emotions toward the therapist consist partly of compliance and ingratiation, and are thus the product of fear rather than of love. Analysis of these pseudo-positive emotions usually brings forth aggressive feelings of which the person was previously unaware.

I referred earlier to the fact that people with depressive personalities remained dependent upon outside sources of self-esteem. It appeared probable that they, for one reason or another, had failed to incorporate any sense of their own worth during infancy and early childhood even in instances where parental love had seemed adequate. **How far are depressive individuals, during long-term counselling or psychotherapy, able to experience the therapist as a loving parent and thus acquire the kind of built-in self-esteem they should have acquired much earlier in life?**

Our knowledge is not yet adequate to answer that question fully. What one can say is that there are certainly **some who do incorporate the therapist in this way and who thus acquire a sense of their own worth which they did not previously possess. I have the impression that these are individuals who, in actuality, did suffer from neglectful or unloving parents.** The transference situation gives such people a second chance, a corrective emotional experience in which they learn that at least one other person values and appreciates them. Moreover, this other person accepts the aggressive, assertive aspects of their personalities as well as the compliant, “good” aspects. However, even these individuals, who may gain a great deal from psychotherapy, seldom lose entirely their tendency to become unduly depressed in adversity. Some degree of vulnerability to depression remains with them.

The Therapeutic Value of Achievement

One way in which depressive personalities ward off depression is by repeated achievement. This is especially true of gifted people, who may often be, in the world's eyes, extremely successful. However, examination of what they actually do often reveals that their attitude toward work is compulsive. They so easily get depressed if they are not working and achieving that they dare not take holidays, or cannot enjoy holidays if they are not perpetually active. They tend to work very long hours and to leave themselves little or no time for family life or relaxation, which they may even dismiss as a waste of time. Often, such people go to bed very late in the hope that they will instantly fall asleep, thus leaving no time for morbid thoughts to enter their minds. Whether or not personalities of this kind display obvious hypomanic symptoms, they are employing a manic defense against depression. Such a defense is often quite effective for long periods.

The fact that repeated achievement can be the consequence of hypomanic overactivity has tended to discredit work as therapy for depression. Yet depressive personalities often underachieve because they have no confidence in their abilities or denigrate their achievements instead of being proud of them. Many depressives possess unrealized potentials, and benefit greatly from recognizing these and putting them to use. Sometimes one finds that such people have prematurely abandoned occupations and leisure activities that they might have enjoyed because they underestimated their capacities or set themselves impossible standards. It is very important for depressives to have some rewarding occupation to turn to that they can still pursue when depression threatens, or when they are already mildly depressed. Intellectuals can often be encouraged to write. Even keeping a diary is valuable, as it enables the writer to objectify his or her moods and thus to detach himself or herself from them to some extent. Others may benefit from learning to play a musical instrument--again, something to which they can turn even when feeling low. In Britain, cultivating one's garden is a rewarding occupation that requires no interaction with others and that brings a sense of achievement to people of all ranges of intelligence. The point I want to emphasize is that, **although work can be a compulsive activity that prevents the person from facing himself or herself and his or her problem, it can also be a way for the depressive to realize more of his or her true potential and thus acquire a greater sense of self worth.** Freud, when asked to define normality, did so in terms of the ability to love and the ability to work. Psychotherapists have tended to overemphasize object relationships and to undervalue work as a legitimate source of self-esteem.

It is encouraging to learn that, in some clinics in the United States specializing in the treatment of affective disorders, every client is offered some form of psychological therapy, even when receiving lithium or antidepressants. I hope this practice will become more general. People with recurrent depression can often gain considerable benefit from psychotherapy whether or not they are also receiving other forms of treatment.

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QUESTIONS BASED ON THIS LESSON:

37. People who seem to be more prone to the experience of depression and to depressive illnesses:

    A. Are usually outgoing and well adjusted as children

    B. Tend to be extremely sure of themselves and able to readily disregard disapproval from others

    C. Often do not stand their ground under attack by othersand have a tendency to retreat from new situations or problems

    D. Never repress aggression and usually direct aggressive feelings outwardly toward people in their environment

38. Women who appear to be more prone to clinical depression:

    A. Usually have several other adults in whom to confide

    B. Often have three or more children under the age of 14 at home

    C. Live in excellent housing conditions

    D. Have many interests outside the home

39. The aim of psychotherapy with depressed individuals is primarily:

A. To resolve early oedipal conflicts

B. To convince depressed individuals that they must live with persistent depression the rest of their lives

C. To help the person make sense of the disorder, understand the relationship between depression and personality style, and cope more effectively with social factors influencing the condition

D. To help the person understand that he or she alone is responsible for how he or she feels and that environmental influences are entirely irrelevant

40. The positive transference that depressive individuals seem to form so readily is:

A. Usually rooted in deep love and respect for authority figures

B. A reflection of strong self-confidence and self-esteem

C. A common mask for paranoid, delusional thinking

D. Partly due to a need to win approval via compliance andto avoid experiencing and expressing aggressive feelings that they fear might lead to rejection

Directions in Mental Health Counseling

VOLUME 1 • LESSON 11

On the Efficacy of Psychotherapy

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EDITOR'S NOTE

Even though most of us spend the majority of our time carrying out some form of psychotherapy with clients, we are all too painfully aware of the difficulties in determining with any degree of certainty that what we are doing for our clients really works. Experience tells us that psychotherapy is extremely helpful, but proving this scientifically has baffled many researchers.

In 1952, the noted British psychologist Hans Eysenck reported that there was no empirical evidence to demonstrate psychotherapy's efficacy. His pronouncement has been challenged ever since, and some studies were designed and carried out to clarify the critical issues involved. For example, studies from the Menninger Clinic indicate that psychotherapy can, indeed, be proved effective--for some clients.

During the past decades, as newer forms of therapy emerged, these were compared with more traditional psychotherapeutic strategies, including psychoanalysis; in general, no one particular therapeutic approach seemed superior to another. In one study involving over 25,000 clients, the results showed unequivocally that psychotherapy was effective, with about 80% of clients being better off after treatment than before and few, if any, deleterious effects of treatment.

Earlier studies suffered from a curious sort of clinical naivete, treating clients, psychotherapy, and psychotherapists as if they were much the same. They are not, of course. As the parameters of evaluation have become more carefully defined, it is now possible to make certain, important conclusions. To begin with, the more favorable the client's level of overall functioning (ego-strength), the more likely he or she will be to achieve substantial therapeutic benefit from most forms of psychotherapy. A client's readiness to undertake psychotherapy is a key factor in its effectiveness. The experience, special talents, and skills of the clinician, and the suitability of the match between client and clinician are critical. Finally, with careful diagnostic evaluation and treatment prescription, based on considerations of indications and suitability of a client for a particular form of psychotherapy, the odds for significant benefit improve substantially.

The indications that have been established for various psychotherapeutic approaches are reviewed.

INTRODUCTION

June 1952. British experimental psychologist Hans J. Eysenck (1952) stuns the psychiatric world with the statement that there is no empirical evidence to demonstrate that psychotherapy has any significant, measured effectiveness. His conclusion is based upon a selective review of formal research studies. Clinicians, however, still continue to recommend and practice psychotherapy and clients still continue to claim they derive substantial benefits. Eysenck's review seems to have had more impact on the academic than clinical community. (Eysenck never did state that psychotherapy was not effective. He only stated there was no evidence from his logical positivist perspective to demonstrate that it did: the null hypothesis that clients treated by psychotherapy improve more than untreated clients was not disconfirmed.)

August 1956. American psychologist Donald Cartwright (1956) challenges Eysenck's conclusion in the same journal and raises questions about the selection of studies and the rendering of the evidence. New formal studies of the efficacy of psychotherapy and the predictability of outcomes are now underway at The Menninger Foundation and at the University of Chicago.

1957-1970. Empirical studies of psychotherapeutic processes and outcomes capture the imagination of academic psychiatrists and psychologists. A groundswell of formal research begins. Most of the research, however, is limited in that it draws upon the work of relatively inexperienced therapists (e.g., residents, graduate students) treating select populations in academic settings. Concerned with the direction that the research is taking, Keissler(1966) echoes past clinical wisdom in the search for a more cogent paradigm. He writes that **questions about the efficacy of psycho-**

therapy can only be posed meaningfully in terms of (1) what kinds of patients benefit, (2) in what kinds of ways, (3) when what kinds of therapies, (4) are applied by what kinds of therapists. This formulation of the question goes back to Oberndorf's(1943) pioneering researches on psychoanalytic outcomes, but it seems that it needs to be stated every decade or so. Still, the times or technology are not quite ripe for such a formulation. Nonetheless, to pool resources, a small group of clinically informed researchers begin to meet annually, and soon a national Society for Psychotherapy Research is formed. The American Psychological Association convenes three interdisciplinary conferences on psychotherapy research. **The results of the more informed Menninger (Kernberg et. al.,1972) and Chicago (Fiske, Cartwright, & Kirtner, 1964) studies are now coming in and providing reliable, formal, empirical evidence to demonstrate the efficacy of psychotherapy for some clients.** Debates continue nonetheless. A new large-scale, methodologically rigorous, multivariate, predictive study is begun at the University of Pennsylvania Medical Center.

1970-1980. New Forms of Therapy germinating during the 1960s come into their own (e.g., cognitive therapy, behavior therapy) **and their efficacy begins to be compared with that of more traditional psychodynamic approaches. Luborsky, Singer & Luborsky(1975) review the growing literature on comparative studies and conclude that all forms of therapy yield equal benefits:** there is no empirical evidence to demonstrate that one form of therapy provides more therapeutic benefit than another for clients as a general class--**the quality of benefit cannot, however, be addressed by the available research.** (Clinicians still continue to make differential diagnoses and treat different kinds of clients differently.) Garfield and Bergin's thousand-page *Handbook of Psychotherapy Research* (1978) is now in its second revision and at the sunset of the decade, Smith, Glass, and Miller(1980) apply an ingenious statistical method ("meta-analysis") to pool the results of all controlled studies. **On the basis of 475 "controlled" studies of "psychotherapy" involving well over 25,000 "patients," they conclude:**

> **The results show unequivocally that psychotherapy is effective...At the end of treatment [the patient] is better off than 80% of those who need therapy but remain untreated.** In absolute terms, the magnitude of therapeutic effect is greater than most interventions in social science. Not only is psychotherapy effective on the average, but **there is scant evidence of negative or deterioration effects of psychotherapy.**

Smith, Glass, and Miller's review is not without its own difficulties, for in their desire to be both comprehensive and rigorous, **most of the studies that they included in their review tend to be clinically naive,** based upon the work of novice therapists and unrepresentative of the everyday world of clinical practice.

1980-1990. The decade where informed clinical practice begins to inform research. Questions about the general efficacy of psychotherapy no longer seem a compelling, or even interesting, issue. Recognition that empirical research had not much influenced clinical practice largely because it did not correspond to the world of informed practice now seems as if it had always been self evident. The National Institute of Mental Health now consents to support only studies of informed practice, germane to serious clinical problems, where it can be demonstrated that the particular kind of therapy being studied is actually being administered at a requisite level of skill (e.g., as assessed through treatment manuals applied to tape records of actual treatments). A major, multicenter collaborative investigation comparing the efficacy of cognitive, interpersonal, and psychopharmacologic treatment of dysthymic disorder is underway (Klerman et al., 1974), though its findings are somewhat equivocal because most of the treatments, including psychopharmalogic, were not administered consistent with research criteria (Prien et al. 1984). Nonetheless, cognitive, interpersonal, and imipramine therapy seemed equally effective, especially in regard to combining psychotherapy with pharmacotherapy in treating dysthymic disorder. Psychoanalysts also begin to publish outcome studies using research methodologies consistent with the level of their data, and the findings from nearly a dozen studies involving more than 1000 clients all tend to converge on the finding that most suitably selected clients treated by psychoanalysis functioning within a non-psychotic range of illness achieve substantial therapeutic benefits (Bachrach et al., 1991). The final account of the Menninger Project (Wallerstein, 1986) and the Penn Project (Luborsky et al., 1988) are now in and suggest **most clients carefully selected as suitable candidates for psychotherapy derive substantial benefits, though it is not easy to predict at the beginning of treatment who, among the seemingly suitable candidates, will benefit to what degree** (Bachrach et al., 1991, Luborsky et al., 1988; Wallerstein, 1986).

Questions about the effects of client-therapist matches are now being considered. In an age of increasing accountability, clinicians and researchers share concerns. All seem to conclude that the once-ambitious questions posed by earlier investigators were premature or ill-conceived. The accumulation of knowledge proceeds by a focus upon small, manageable questions where there exist means of finding answers. **No one research model or method, be it the model of experimental psychology, psychoanalysis, or hermeneutics, is equally well suited to all questions.** Answers to questions about the efficacy of psychotherapy must come from many perspectives, from the level of clinical observation of the consulting room to formal research strategies. The decade ends with the question of which therapy for whom and for what?

1990-present. Diagnostic Specificity and Treatment Planning. For whatever its limitations, the DSM series brought a measure of reliability to classification. Increasingly, the relationship between the type of therapy, administered by whom, for what kind of client, experiencing what manner of psychopathology, commands center stage. The decade begins with a decided focus upon the relationship between the indications for a particular form of treatment, the client's suitability for a given form of treatment, and the demonstrated effectiveness of these treatments for the psychopathology of individual clients. The gap between actual clinical practice and formal research narrows as clinicians are now actively engaged in the research enterprise. However, the field is still not prepared overall to conduct formal studies meeting meaningful criteria for effective outcome research, especially in relation to the comparative efficacy of different treatments, in part, because effective and applicable methods of assessing of treatment processes and outcomes have not yet been brought to the point of sophisticated clinical specificity and meaningfulness. **The development of such methods remains one of the main challenges to the field in the new decade.**

THE EVALUATION OF EFFICACY

There are many factors that need to be carefully considered in the evaluation of efficacy. These include the following:

1. **The Clinical Condition Being Treated: Psychotherapy is not a panacea for all psychopathology. Its effectiveness can only be evaluated in terms of the extent to which one might reasonably expect a given clinical condition to be ameliorated at a given state of knowledge.** For example, some conditions, such as autism, are not known to be systematically amenable to any form of treatment. Other conditions, such as certain schizophrenias, may be arrested or stabilized by pharmacologic and/or psychotherapeutic means, though, as in diabetes, the fundamental condition is not known to be alterable. Other conditions, such as certain borderline disorders, may be amenable with difficulty while others, such as certain depressive states, may be readily amenable. **Viewed in this light, the matter of efficacy becomes a question of the extent of reasonably expectable influence rather than cure, and the degree and quality of change in comparison to what can be achieved by other treatment methods.** If a given form of psychotherapy results in improvement of a given clinical condition more than other forms of treatment for the same condition, it would certainly be regarded as effective. If, however, it is shown to be helpful, but not as helpful as other forms of treatment for that condition, the degree of efficacy would have to be viewed in another light.

2. **The Type of Psychotherapy in Relation to Clinical Conditions:** Insofar as we understand incompletely both the pathogenesis and the action of different forms of psychotherapy, **one can evaluate only the efficacy of a particular kind of psychotherapy in relation to a specific clinical condition or class of conditions.**

To speak of efficacy in general terms is about as meaningful as speaking about the efficacy of education or surgery. The key questions are what kind, for what, when, etc.

3. The Suitability of the Client for the Treatment: Broadly speaking, all forms of treatment present tasks to clients. Implicitly or explicitly, they require clients to do certain things and assume clients have the ability to do these things. Some cognitive-behavioral therapies, for example, require clients to construct precise hierarchies of conditions surrounding the appearance of symptoms. They thereby assume clients will have the capacity for precision and be able to construct such hierarchies. If clients cannot do so, they cannot be considered suitable candidates for this form of treatment. Another modality, psychoanalysis, assumes that clients are able to respond with self-observation and candor rather than action in the face of strong feeling. Clients unable to do so are therefore not suitable candidates for psychoanalysis. **In general, all forms of psychotherapy require that clients be able to participate actively in the treatment process and to some extent entertain the idea that their lot, at least in part, is a product of their attitudes, desires, perceptions, values, etc. Therefore, no matter what the indications are for any given form of treatment, the efficacy of that treatment also depends upon the client's ability to engage in the treatment procedures.** But as there are many different kinds of people, treatment prescriptions must take into account who the client is, how he or she sees the world, and what his or her natural proclivities are for dealing with problems. Obvious as these points may be, they are often overlooked.

The efficacy of a particular form of psychotherapy for a given clinical condition can therefore only be meaningfully evaluated if the client possesses the requisite capacities and abilities to engage in the treatment effort, i.e., the tasks implicit to the treatment method. As in sculpting, one can only work with the substance and grain of the marble. To go against the grain is to invite misfortune. In clinical terms, going against the grain of the marble may mean incomplete diagnosis, an errant treatment prescription, or limitations of experienced and technical skill.

A DEFINITION OF PSYCHOTHERAPY

Psychotherapy may be best defined as a clinical procedure governed by systematically conceptualized and specified rules of technique, rationally derived from a systematic body of knowledge regarding psychopathology and the human condition. Its means of influence are verbal and its aim is to ameliorate psychological stresses, symptoms, and/or conflicts.

From this definition it follows that simply talking to clients, *per se*, or counseling them, helpful as this may sometimes be, should probably not be regarded as psychotherapy. The main forms of psychotherapy today include cognitive, cognitive-behavioral, psychoanalytically oriented psychotherapy, and psychoanalysis. These categorizations are only generic, and each in turn also subsumes a variety of approaches. Psychotherapies may also be classified according to their degree of expressiveness or supportiveness, i.e., the extent to which techniques aim toward modifying or strengthening attitudes, defenses, and coping styles.

EFFICACY AND THE PRESCRIPTION FOR PSYCHOTHERAPY

As has been suggested, the efficacy of any clinical procedure, including psychotherapy, can be meaningfully considered only in the broader context of where its administration is and is not indicated. In relation to the prescription for a particular modality of psychotherapy, it has proven especially useful **to make distinctions between indications for the form of psychotherapy and the client's suitability in terms of psychological make-up and resources.**

About the only general statement one can make about the prescription for psychotherapy is that the higher the client's overall level of psychological function (i.e., ego-strength), the more likely the client will be able to benefit from most forms of psychotherapy. (Garfield & Bergin, 1978) The more impaired the client, the more guarded the prognosis. This is only to state the somewhat obvious proposition that the more effective resources people have and the more effectively they have been able to make use of their developmental learning opportunities, the more likely they will be to make productive use of the opportunities provided by psychotherapy. This is well illustrated by the finding of **the Menninger Foundation Psychotherapy Research Project. Clients initially misdiagnosed as having severe impairments in ego-functioning and placed in supportive psychotherapy achieved substantial benefits, at times close to the levels achieved by clients of high ego-strength treated by the most expressive form of psychotherapy. Clients initially misdiagnosed as having high levels of ego strength and placed in the more expressive forms of psychotherapy did poorly and sometimes deteriorated(Horwitz, 1974).**

SOME SPECIFIC MODALITIES

Psychoanalysis: Psychoanalysis continues to be the most therapeutically ambitious and demanding form of psychotherapy. It is therefore indicated only for conditions generally refractory to less demanding approaches and in areas where it has proven its mettle. It is never indicated for transient, situational, or relatively minor conditions. **It is probably the treatment of choice for seriously consequential disorders of intrapsychic conflict such as character neuroses and characterological anxiety or depressive states.** Common indications include the character neuroses, including masochistic and narcissistic personality disorders, and major impairments of interpersonal or vocational functioning deriving from intrapsychic conflict, i.e., difficulties in forming lasting, intimate relations with persons of the opposite sex or the recurrent undermining of opportunities for advancement and success. Even though a wide range of persons may experience such difficulties, **psychoanalysis is generally suitable only for persons functioning within a neurotic range of ego-weakness and whose character attitudes and values are given to autoplastic modes of coping. Such persons typically are psychologically minded, seeking treatment to change something about themselves, with good ego-strength, relatively mature object relations, and capacities for response to stress by thought more than action.**

Psychoanalysis has clearly been shown to yield high levels of therapeutic benefits for disorders of intrapsychic conflict among clients functioning within a neurotic range of ego-weakness. (Erle, 1979; Erle & Goldberg, 1984; Kernberg et al., 1972; Weber, Bachrach & Solomon, *in press*.) The clinical literature and general clinical lore also suggests that among suitable clients treated by psychoanalysis the levels of therapeutic benefit and their resilience is higher than similar clients treated by psychotherapy. Few formal comparative investigations of this distinction have been undertaken, but there is a mounting body of formal research that tends to support the clinical wisdom (Kernberg et al., 1972; Weber, Bachrach & Solomon, *in press*). Psychoanalysis is clearly contraindicated for clients functioning within a psychotic range of ego weakness and for most clients functioning within a borderline range (Bachrach & Leaff, 1978).

Psychoanalytically Oriented Psychotherapy and Related Expressive Psychotherapies: These are indicated for a wider range of conditions than psychoanalysis proper and for a broader range of clients. In its many variants (from short-term expressive psychotherapy to longer-term approaches) it can be indicated for **transient disturbances, symptomatic affect states, and more circumscribed characterological conditions.** It may also be indicated **where psychoanalysis is indicated, but when the client's level of ego functioning, attitudes, or reality circumstances do not permit psychoanalysis.** Either expressive or supportive psychotherapy are generally regarded as the treatment of choice for borderline personality organization, depending on the client's psychological resources, though adjunctive procedures (e.g., hospital management, pharmacotherapy) may also be required. **Expressive psychotherapy is generally contraindicated if used alone or as the primary treatment method for client's functioning within a psychotic range of ego weakness.** Formal research studies show that **most clients suitable for expressive psychotherapy achieve considerable therapeutic benefit, especially for anxiety disorders, non-major affective disorders, and for delimited characterological difficulties** (Kernberg et al., 1972; Luborsky et al., 1980). In conjunction with pharmacotherapy, it has also shown to be helpful in the treatment of a range of psychotic conditions (Garfield & Bergin, 1978).

Cognitive Psychotherapy: Cognitive therapy is a relatively recent approach to psychotherapy pioneered by Ellis (1962) and Beck (1976). Although there are many varieties of cognitive therapy (lately it has also been combined with elements of behavioral therapies into what is termed cognitive-behavior therapy), it is **generally indicated for non-major affective disorders and anxiety disorders that impinge upon interpersonal and vocational functioning and for certain disorders of self-esteem** (Beck, 1976; Garfield & Bergin, 1978). Because of the premium that these approaches place upon rationality and precision of thought, they are generally suitable mainly for persons with autoplastic modes of coping and with ideational, precise cognitive styles, such as obsessive-compulsive personalities. These approaches are **not indicated in the full treatment of borderline, psychotic, or major characterological conditions.** The above recommendations regarding indications and circumstances of suitability for cognitive therapy have received substantial support from formal research (Garfield & Bergin, 1978).

Miscellaneous Other Therapies and Combinations of Therapies: There is a wide range of other forms of psychotherapy currently being employed, especially as an outgrowth of the Human Potential Movement (e.g., Gestalt therapy, Primal Scream therapy), about which **indications and suitability has not been systematically investigated.** These approaches vary in their degree of expressiveness and supportiveness. **Generally, however, it would seem they are contraindicated in severe borderline or psychotic conditions.**

Combination Therapy: Many therapies are also employed in combination. For example, **there are reports of pharmacotherapy in combination with cognitive and/or psychoanalytic psychotherapy in the treatment of depression and**

schizophrenia being more effective than either method used alone (Garfield & Bergin, 1978). Behavioral treatments have shown merit in the treatment of simple phobias, inhibitions, and stress-related conditions and are also being employed in combination with other approaches. Although it is generally accepted today that pharmacotherapy is indicated in the treatment of major affective disorders and psychoses, in the past successful treatment of these conditions by variations of long-term psychoanalytic psychotherapy has been reported. Little is understood about these reports; treatments and their effectiveness may be specific to the qualities and resources of the client, the special talents of the therapist, and the suitability of the personal match between client and therapist.

GENERAL CONCLUSIONS REGARDING THE EFFICACY OF PSYCHOTHERAPY

By this time, a substantial clinical and formal research literature has developed to support the view that **most clients wisely chosen for specific forms of psychotherapy achieve substantial therapeutic benefit.** At the same time that literature shows that though clients benefit as a class, **it is not possible to predict with substantial accuracy which of those carefully selected clients will benefit to what extent.** Substantial literature also exists on the kinds of clients not likely to benefit from most forms of psychotherapy (Baekeland & Lundwall, 1975).

Some argue that the relative unpredictability of therapeutic outcomes among carefully selected clients is a function of the limitations of current diagnostic methods. Others, such as Freud, have argued that it is not possible to obtain all the necessary information regarding a client's suitability in initial assessment, and that the human condition and the psychotherapeutic interactions are so complex that full predictability will never be possible. Some general conclusions may, however, be drawn.

1. **The more favorable the client's level of overall functioning (ego-strength), the more likely it will be that the client will achieve substantial therapeutic benefit from most forms of psychotherapy.**

2. **A client's readiness to undertake psychotherapy is a key factor in its effectiveness.** One's readiness to undertake psychotherapy may vary with circumstances and different points in one's life.

3. **With careful diagnostic evaluation and treatment prescription based upon considerations of indications and suitability for a given form of psychotherapy, the odds for significant therapeutic benefit improve substantially.**

4. The experience, special talents, and skills of the therapist, and the suitability of the match between client and therapist, are significant influences.

5. With the present state of knowledge **it is difficult to be as precise as one might like about the specific indications and conditions of suitability for the particular modalities of psychotherapy.** In the final analysis, much still depends upon the clinical circumstances of each case.

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QUESTIONS BASED ON THIS LESSON:

41. In 1952, Hans J. Eysenck reported that:

A. Psychotherapy combined with chemotherapy had a better effect in depressed clients than either approach alone

B. All kinds of psychotherapy were ineffectual, based on long-term, double-blind control studies

C. There was no empirical evidence to prove psychotherapy to be effective, based on a selective review of formal research studies

D. Clients receiving psychotherapy from experienced clinicians did better than those treated by inexperienced ones

42. Which of the following statements is/are correct?

A. Luborsky's review of literature concluded that cognitive and Jungian psychotherapy yields better results than any other form

B. Smith, Glass, and Miller concluded that clients who receive psychotherapy are better off than 80% of clients who do not

C. Smith, Glass, and Miller concluded that psychotherapy often had a negative or deteriorative influence on clients

D. The National Institute of Health has recently declined to support psycho therapy studies that are germane to serious clinical problems and where the therapy given is administered at a requisite level of skill

43. Which of the following statements is/are correct?

A. The higher a client's overall level of psychological functioning, the more likely he or she will be to benefit from most forms of psychotherapy

B. Ego-strength is not a factor influencing outcome of psychotherapy

C. The more chronically impaired the client, the better the prognosis

D. The greater the client's capacity for learning, the better the response to psychotherapy

44. In the report of Menninger Foundation Psychotherapy Research Project:

A. There was no substantial evidence of the efficacy of psychotherapy

B. Clients misdiagnosed as having serious ego deficits and later shown to have good ego strength did poorly in supportive psychotherapy

C. Clients misdiagnosed as having high levels of ego strength, and later shown not to, did poorly and at times even deteriorated during expressive psychotherapy

D. Younger therapists had much better results than older ones

Directions in Mental Health Counseling

VOLUME 1 • LESSON 12

The Diagnosis and Treatment of Multiple Personality Disorder

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BACKGROUND

Multiple personality disorder (MPD) is being recognized, diagnosed, and treated with increasing frequency, and is fast becoming the subject of considerable study and research. Within the last decade five major journal issues have been dedicated to MPD (Braun, 1983*a*, 1984*a*; Kluft, 1984*a*; Loewenstein, 1991*a*; Orne, 1984), and *Dissociation*, a journal specializing in the study of the dissociative disorders, has begun publication. Also, three scholarly bibliographies have been compiled (Boor & Coons, 1983; Damgaard, Benschoten & Fagen, 1985; Goettman, Greaves & Coons, 1991). The International Society for the Study of Multiple Personality and Dissociation was formed, and rapidly grew to more than 2000 members. It has become increasingly clear that the distribution of this condition is widespread if not worldwide (Coons, Bowman, Kluft & Milstein, 1991). Well-documented and thoughtful research studies, reviewed in Putnam (1984*a*, 1991*a*, 1991*b*), explore the psychophysiological correlates of the personality states and the switch phenomenon. Follow-up studies of treatment results (Coons, 1986; Kluft, 1984*b*, 1986) have become available, and the discovery of children with MPD has been documented (see Coons, 1985; Fagan & McMahon, 1984, Hornstein & Tyson, 1991; Kluft, 1984*c*). A comprehensive exploration of the childhood experiences of these patients has been published (Kluft, 1985*a*), and their family constellations have been described (Kluft, Braun & Sachs, 1985). The natural history of MPD is slowly being explored, and its presentations from childhood to senescence illustrated (Kluft, 1985*b*, 1991*a*). Taylor and Martin (1944) noted the literature contained approximately 100 cases of MPD. In 1980, Bliss said approximately 200 cases had been reported. Braun (1984*b*) observed there were approximately 1000 contemporary cases of MPD in treatment, and Kluft (1985*c*), who polled 70 students attending a course on MPD, found they had encountered 267 previously unreported cases. A recent comprehensive review (Kluft, 1991*b*) reported several large series of contemporary MPD patients, ranging from 50 to 355 subjects. More than a dozen special centers for the treatment of MPD patients have developed.

MPD has always been and may well continue to be a controversial entity. Lay accounts that exploit MPD for sensationalistic ends can make this condition appear a subject more fit for a soap opera than for science. **The condition has been closely associated with a history of child abuse** (Putnam, Guroff, Silberman, Balban & Post, 1986; Ross, Norton & Wozney, 1989; Schultz, Braun & Kluft, 1989; Wilbur, 1984, 1985). Although the alarming prevalence of the mistreatment of children is slowly achieving long-overdue recognition, these patients' accounts can seem so repugnant, farfetched, or incredible as to become intolerable, thus promoting a defensive denial and derealization on the part of the clinician. The clinician's attitudes may then manifest as skepticism (Goodwin, 1985). **Even experienced workers in the field report countertransference experiences of wishing to distance themselves from the client and disavow the possibility that what they are hearing is true.**

The specter of iatrogenesis has long been associated with MPD, especially when the use of hypnosis is cited. In the older literature, with unclear diagnostic criteria and a relative naivete about the effects of expectation and suggestion, many clients reported as suffering from MPD may not have been. However, many continue to suspect all cases may be artifacts. The publication of *Sybil* (Schreiber, 1973) was followed by an article entitled "*Sybil*: Grande Hysterie or Folie a Deux" (Victor, 1975*a*). Two articles reviewed the experiments and materials adduced to support the artificial creation of classic MPD and found no data to sustain such a stance (Braun, 1984*c*; Kluft, 1982). A recent symposium on the subject sustained this impression (Kluft, 1989).

DEFINITION AND DESCRIPTION

MPD is a severe dissociative disorder involving a disturbance of both memory and identity (Nemiah, 1981). Putnam, Loewenstein, Silberman, and Post (1984) observe, "The existence of multiple amnestic episodes, together with the presence of alternating separate and distinct identifies, distinguishes multiple personality disorder from all other psychiatric syndromes." They agree with Kluft (1985*b*) that stigmata suggestive of concurrent or alternative diagnoses are almost invariably present and note that if the features of MPD are documented, it should be regarded as a superordinate diagnosis in which other manifestations are often encompassed (Putnam et al., 1984). This is a pragmatic clinical stance. Compelling data show that clients often do well with treatment that addresses their MPD (Kluft, 1984b, 1986), and disheartening data descriptive of clients whose MPD was not recognized and treated, and who failed to respond to over a decade of "competent" but misdirected therapy (Kluft, 1982, 1984*b*, 1985*b*).

DSM-III-R offers the following diagnostic criteria for MPD: "A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self). B. At least two of these personalities or personality states recurrently take full control of the person's behavior" (American Psychiatric Association [APA], 1987).

Amnesia is a strongly associated feature, but not an essential criterion in DSM-III-R. There is ample discussion on this point. Coons (1984), among others, sees amnesia "as an absolute essential criterion for the diagnosis." Solomon (1982) and Solomon state, "The degree of awareness which the personalities have of each other can vary dramatically from one case to another." Ellenberger (1970) has described many patterns of amnesia, including minimal (mutual cognizance), complete (mutual amnesia) and partial or unidirectional forms. Braun (1986) notes one often sees an apparent absence of amnesia, which reflects one personality's having learned of but not experienced another's experience, thus reporting knowledge as memory. I observed one can "forget one forgot" and offer a report devoid of reference to amnesia. **Acknowledgment of amnesia is often difficult for the client**, who equates amnesia with craziness, or, having become accustomed to a discontinuous experience of time, assumes this is the normative experience and handles the interviewer's questions in a counterexpectational manner.

> Often personalities are aware of some or all of the others to varying degrees and may experience the others as friends, companions, or adversaries. Some personalities may be aware of the existences of other personalities but have no direct interaction with them. Some may be unaware of the existence of the others. At any given moment, only one personality interacts with the external environment, and none or any number of the other personalities may actively perceive (i.e., "listen in on") or influence what is going on. The personality that presents itself for treatment often has little or no knowledge of the existence of the other personalities.
>
> Most personalities are aware of lost periods of time or distortions in their experience of time.... Others are unaware of their amnestic experiences, confabulate memories that cover the amnestic periods, or have access to the memories of other personalities, which they report as if they were their own (APA, 1987).

As of this writing, it appears that DSM-IV will adopt an amnesia criterion, notwithstanding residual difficulties in regard to its application.

In the reported literature, **MPD has a 4:1 to 9:1 female predominance.** Many argue males with MPD encounter difficulty with the law and enter the criminal justice rather than the mental health system. Hence, their pathology goes unrecognized. **Most cases in the older literature appear to have involved dual or triple personalities** (Talyor & Martin, 1944). **Two series reported an average of 13.331 and 13.9 personalities** (Kluft, 1984*b*); **a third described a modal range of 8-13 (Kluft, 1984*d*); and 44.2% of a series of 70 had 11 or more** (Kluft, 1991*c*). Very complex cases are not infrequent, and the successful treatment of clients with over 100 alters has been reported (Kluft, 1991*c*). The older literature seemed to report cases with a small number of discrepant and apparently opposite personalities, frequently the "retiring spinster" and the "flamboyant, promiscuous bar habitue" (APA, 1980). One text suggested the most common alter was a persecutor in form (Beahrs, 1982). Actually, studies of large series challenge long-held preconceptions. **The most frequent alter personalities are scared children, who embody the clients' experience of traumatic events** (Kluft, 1984*d*; Putnam et al., 1986).

It is useful to bear in mind that the term "personality," although venerable and clinically useful, is conceptually misleading and lends itself to considerable confusion. **In talking with clients, it is counterproductive and inappropriate to use technical terms** like "subpersonalities," "fragments," "ego states," or any variety of terms currently in use in the literature. On the other hand, it is erroneous for the clinician or researcher to concretize or reify the term "personality" in his or her efforts to understand the client. I (1985*b*) have followed the changes in personality configurations of MPD patients from latency to senescence, observing that "what is essential to MPD across its many presentations is no more than the presence, within an individual, of more than one structured entity with a sense of its own existence. Such entities are, by tradition, called personalities. However, **the term 'personality' may imply a higher degree of elaborateness than is consistent with clinical reality in**

certain cases, and imply as well that such complexity is essential to the condition." Kluft (1984*d*) has also stated, "When there are several personalities, there may be some of which, were they the only other personality, would not have sufficient definition to qualify the patient for the [DSM-III] diagnosis of MPD." Coons (1984) also is cautionary.

The personalities' overt differences and separate self concepts range from minimal divergence to extreme polarity. Personalities usually, but not inevitably, have names of their own. They may perceive and represent themselves as different in age, race, gender, and sexual orientation. They often claim origin from a different family; occasionally they claim origin from a different culture and/or epoch. Their values, beliefs, and symptom pictures may be different, and they may be preoccupied with relatively different issues and problems. In classic cases, alters may have separate wardrobes, possessions, pursuits, and interpersonal styles. Sometimes different alters have different jobs and social circles. Not uncommonly different alters, assessed at different times, are given different diagnoses.

Personalities may show differences in handwriting. These range from preference of printing versus cursive to differences of style and different handedness. Their voices, vocabularies, speech patterns, accents, pitch, rhythm, and even preferred languages may vary. The movement characteristics of each alter may be sufficiently distinct as to constitute a virtual "action signature." Their facial expressions, both when "neutral" and affectively engaged, may be different on a dramatic and consistent basis. When personalities have pursued different interests, acquired wardrobes and possessions that reflect their separate tastes, interacted with others extensively, and become invested in their separateness, their distinctness can be quite marked. Conversely, when they remain relatively bound to their original defensive purposes and attempt to remain hidden from detection, their differences may appear so bland as to call the diagnosis into question (Kluft, 1985*b*, 1991*a*).

The personalities usually come into existence to serve defensive purposes. Over time, they may come to acquire a high degree of secondary autonomy and narcissistic investment in separateness. Their perception of autonomy may approach an intensity Coons (1980, 1984) and I (1984*c*) have termed "pseudo-delusional." In such instances, the others are so strongly experienced as separate, not-me, and ego alien that an alter may behave as if its actions are irrelevant to it. They may try to kill one another, refusing to concede the death of one dooms all, or experience the body as an object and a possession of another alter, and, with consummate "trance logic" (Orne, 1959), use the body to attack the body and proclaim that the personality to which they attribute the body has been punished or mutilated while they remain untouched.

Several terms proposed by Braun (1986) are often used to describe certain phenomena. **The "host personality" has executive control of the body the greatest amount of time during a given period. The "presenting personality" presents itself for therapy. The "original personality" is a theoretical construct that denotes the identity from which the first other personality splits off. Some consider these concepts crucial, others do not.** No "type" of personality is invariably present. **The classic host personality is often but not inevitably the presenting personality that seeks treatment** and is commonly depressed, anxious, somewhat neurasthenic, compulsively good, masochistic, and conscience-stricken. It is usually constricted hedonically, and suffers both psychophysiological symptoms and time loss or distortion. **Child-like personalities are quite common;** often there are several. Some are fearful, some recall and encapsulate traumatic memories, some are love/approval-seeking, and still others may preserve the idealized potential for happiness, growth, and the healthy expression of feelings that traumatization has distorted in others. Protectors, helpers, friends, and advisers, occasionally assuming the serene rational stance Allison (1974) described in *Inner Self Helpers* (ISHs), also are encountered. As might be expected, they may take the form of idealized figures, friends, playmates, kind relatives, positive aspects of ambivalently perceived objects, or culturally sanctioned images of benevolence or caring. Personalities based on identifications with aggressors, or which are constructed upon culturally sanctioned images of malevolent intent often become internal persecutors, involved in intropunitive behaviors. Their voices often are perceived as hallucinations, sometimes with command intensity pressuring the client toward self-harm. Some personalities are guardians of memories and secrets. Some serve as memory traces for the common overall experience. Others may be impervious to pain and usually develop out of autohypnotic efforts to block out suffering. Still others may express forbidden impulses, serve as avengers, defend or apologize for abusers, undo by incorporation/identification the loss or feared loss of significant others, or serve very specialized functions. In some clients, many personalities' structures are quite frail and seem to represent a friable self-structure connected to a traumatic episode. Such alters often vanish after abreaction.

ASSOCIATED FINDINGS

MPD is rarely the initial presentation in the MPD client. A clinician's index of suspicion is usually low, and most MPD clients try to disguise their condition (Kluft, 1984*d*, 1985*b*). Keep in mind a number of observations, condensed from more extensive work by Bliss (1980), Braun (1986), Kluft (1984*d*, 1985*b*) and Putnam et al. (1986). **The MPD client, if interviewed with a full mental status and medical review of systems, often has a polysymptomatic pleiomorphic presentation and a complex history.** The modal MPD history entails years, for the client, within the medical system with unsatisfactory resolution of numerous somatic complaints, overlapping and/or followed by years of misdiagnosis in the mental health care delivery system (APA, 1987). Therefore, any client who does not respond appropriately to conscientious trial of conventional medical and/or psychotherapeutic intervention should be assessed for a dissociative disorder (Kluft, 1985*b*). Putnam et al. (1984) concur stating, "[MPD] should be considered in cases where there have been multiple diagnoses, failure of conventional treatments, a mixture of psychiatric and somatic symptoms, and/or extremely rapid shifts in symptoms and levels of function."

Diverse symptoms are frequently reported. It might seem parsimonious to suggest the coincidence of MPD with the Briquet syndrome in many cases or to say this is the "polysymptomatic polyneurosis" of the borderline state, but a close review indicates **symptoms are included from anxiety disorders, somatoform complaints, affective disorders, thought disorders, and borderline states, thus the pragmatic usefulness of the concept of MPD as a superordinate diagnosis** (Putnam et al., 1984). Findings are nonspecific but common in MPD and usually reflect the intrusion of dissociated aspects of the mind, the partial spontaneous revivification of repressed experiences, conflict among alters for control, etc. To a certain extent, the DMS-III criteria are misleading. They imply personalities' dominance, when in executive control, is complete. **Clinical experience indicates personalities not in control may try to take over, influence, or intrude without any overt ongoing psychosocial stress. Alters often overhear and see one another as hallucinations** (Bliss, 1984; Kluft, 1984*d*, 1991*a*). When they contend for control or when dominance is uncertain, headaches, confusion, and terror, along with numerous psychophysiological symptoms, are common.

THE NATURAL HISTORY OF MPD

Many problems associated with diagnosing MPD can be clarified by a study of the condition over time (Kluft, 1985*b*). When comparing clients diagnosed at different ages, and reassessing MPD clients who decline treatment but return years later, certain principles emerge. **First, not all clients who can be diagnosed as having MPD at one point in time are always able to be clearly diagnosed at other points in time.** Although perhaps one client in five has classic MPD over a marked period of time and another consistently keeps his or her signs well hidden, **60% go through periods in which the pathology is intrusive and symptomatic and periods in which it is quiescent and its existence is suppressed and may be denied.** In some cases, years go by with little overt dissociative activity. Many such clients, with their secretiveness, suppression/denial, and periods with little dissociative activity, have only certain temporal **"windows of diagnosability." At those times, the diagnosis can easily be made;** at others, it may be missed completely.

The second principle is that **overtness is not a basic ingredient of MPD.** Overtness of phenomena is related to the alters' modes of interaction, manner of influencing one another, type of hierarchy, battles for control, and narcissistic investment in separateness. When alters cooperate, collude to pass as one, have inner dialogues, and establish a power distribution in which suppression is vigorous, little may emerge. If there is contention but some collaboration, alters intrude rather than have dialogues, and dominance is incomplete. The client often is polysymptomatic but shows little of the overt symptoms of MPD. **If the alters are narcissistically invested in separateness--and tend to have specialized roles--but contention is low, a smooth but overt system of alters may be evident. Such clients often value their MPD. If the same conditions prevail, but with contention, the client may show the classic picture of major shifts of personality dominance**

in response to psychosocial stressors and inner battles, and emphatic differences among alters will become manifest (Kluft, 1991*a*).

GENERAL DIAGNOSTIC CONSIDERATIONS

Because the condition is pleiomorphic, is often covert, and may be unobtrusive for long periods--and the client may resist sharing data relevant to the diagnosis--there is the inevitability of frequent false-negative findings. **The conscientious clinician need not despair if MPD is later diagnosed in a client in whom MPD phenomena was not perceived previously.** Expertise and experience is no safeguard.

In one research series, 5% presented as self-diagnosed but were generally disbelieved by their therapists, 15% openly dissociated during assessment or treatment (usually after months or years), 40% presented with signs could alert a clinician with a high index of suspicion, and 40% were very highly disguised but were discovered in field testing of specialized diagnostic protocols (Kluft, 1982, 1984*d*). What is crucial is to **include MPD in every differential diagnosis, and to have a high index of suspicion for it when treatments fail to prosper, when the client relapses for no apparent reason, and when the client received a number of diagnoses, seen a number of therapists, or had a kaleidoscopic or fluctuating symptom picture.** As noted, it is unlikely that the clinician's interventions will "create" MPD. It is productive to err on the side of overconsideration of the diagnosis. A series of 100 MPD clients was found to have averaged 6.8 years between their initial mental health assessment and an accurate diagnosis (Putnam et al., 1986). The public health consequences of such delays are staggering in terms of the waste of time and resources and appalling in that three studies have shown that the abuse by MPD clients of their own children and/or the children's exposure to MPD can yield yet another generation with MPD (Braun, 1985; Coons, 1985; Kluft, 1984*d*, 1987*a*).

SIGNS SUGGESTING MPD

Some of the findings alluded to above have proved highly useful as signs to suggest careful scrutiny for MPD. Condensing lists by Greaves (1980), Kluft (1984*d*, 1991*b*), and Putnam et al. (1986), they are:

1. **prior treatment failure**
2. **three or more prior diagnoses**
3. **concurrent psychological and somatic symptoms**
4. **fluctuating symptoms and level of function**
5. **severe headaches**
6. **time distortion or time lapses**
7. **being told of disremembered behaviors**
8. **others' noting observable changes**
9. **discovery of productions, objects, or handwriting in one's possession that one cannot account for or recognize**
10. **the hearing of voices (>80% experienced as within the head), experienced as separate, urging toward some good or bad activity**
11. **the use of "we" in a collective sense**
12. **the elicitability of other alters through hypnosis and/or amytal**
13. **a history of child abuse**
14. **an inability to recall childhood events from the years 6 to 11.**

Item 11 is widely cited but some believe it occurs only with initial coconsciousness or after barriers are broached in treatment. Item 12 is subject to cautions cited earlier.

INTERVIEW INQUIRIES

The clinician must be alert to brief evidences of forgetfulness and fluctuations of voice, speech, and movement characteristics within the interview, as well as overt dissociation into alters and positive responses on suggestive items. **A surprising number of MPD clients avert or partially cover their faces and lower their voices to minimize the clinician's detection of such evidences. Although Goodwin** (1982) **has noted similar behaviors in child and adult sex-abuse victims, these signs are not yet generally recognized as suggestive of MPD as well.** Sometimes clients suspected of MPD reveal themselves if assigned to **write a diary 30 minutes a day:** alters intrude, and different writing is noted. **I have yet to find a client with currently active MPD who does not dissociate if the interview is extended to four hours, but the technique is rarely pragmatic** except under forensic circumstances.

Inquiry about traumatic experiences common in MPD histories can be raised later, but often they are denied by or inaccessible to the presenting personality. Unless recent, distressing, and ego-dystonic dissociation has occurred, **direct inquiry about amnesis is often met with denial or unwitting confabulation.** Many clients are too mortified to report they have regained awareness in strange places, or have engaged in activities they consider out of character and/or reprehensible. Therefore, **indirect inquiry**, such as asking about unexplained objects, possessions, productions, and writing **is less threatening,** as is asking about unexplained relationships and/or changes in relationships. **Ask if people unknown to the client address him or her as if they were known to the client, and/or by a different name.** Ask if people ever act as if their relationship to the client had been influenced by factors of which the client was unaware. Also ask about the **presence of inexplicable skills and**

knowledge--or the absence of expected ones. Irregular school and/or work performance is common. Often dissociative experiences of childhood are reported undefensively. Three checklists for suspecting the presence of childhood MPD have been published (Fagan & McMahon, 1984; Kluft, 1984*c*). **Most MPD clients were noted to be "in a trance" or considered liars as children,** usually because they disavowed behavior others observed. Inquiry about imaginary companionship in childhood is advised on theoretical grounds, but clinical findings thus far are equivocal.

A new and promising area for diagnostic inquiry is the use of the Schneiderian first rank symptoms of schizophrenia as indicators of MPD (Kluft, 1987*b*). **MPD clients reported made feelings, made impulses, made volitional acts, voices arguing in the head, influences playing on the body, thoughts ascribed to others, thought withdrawal, and voices commenting on their actions, in diminishing order of frequency--phenomena that were experienced as imposed in some way rather than emanating from within their own psyche.**

Often the clients dissociated or showed signs that suggested MPD as those forms of inquiry were pursued. **Not uncommonly, inquiry about a suggestive or problematic area precipitated a headache or symptom, and exploration of the client's subjective experience disclosed he or she was hearing inner voices or comments.** Thereafter, alters sometimes emerged overtly and spoke through a voice the presenting personality heard and reported, or issued a written statement. Overt communication sometimes happened at that moment, or weeks to months later.

Several additional approaches to diagnosis have emerged recently. The Dissociative Experiences Scale of Bernstein and Putnam (1986) is a valuable screening instrument. Loewenstein (1991*b*) has published a valuable mental status exam for the detection of MPD, and Ross (1989) has published a structured interview, the Dissociative Disorders Interview Schedule, that is said to detect up to 90% of MPD clients. Steinberg, Rounsaville, and Cicchetti (1990) have devised the equally, if not more, sensitive Structured Clinical Interview for the Diagnosis of DSM-III-R Dissociative Disorders that can detect deliberate attempts to dissimulate MPD.

It is not unusual for there to be signs suggestive of MPD, or for the diagnostic issue to be unresolved pending direct contact with an alter, despite ample historical and suggestive data. Likewise, **the diagnosis may seem firm from ancillary sources, yet the clinician has had no direct contact with an alter. Under such circumstances, the clinician must consider the use of hypnosis or amobarbital (Amytal).** Braun (1984*d*) states, "I withhold the use of hypnosis until I have exhausted other means," but he does not advocate an indefinite delay. A number of papers opine that the risks of inducing MPD by such an approach are highly overstated (Braun, 1984*c*; Gruenewald, 1984*a*; Kluft, 1982, 1989). For this reason, judicious hypnotic inquiry can play a valuable role in clarifying the diagnostic situation. **Such inquiry should not be undertaken by the inexperienced or by those unaware of normative ego state phenomena that may be misinterpreted as MPD (Kluft, 1982). Also, it should not be pursued unless the clinician is adequately trained in hypnosis, has sufficient time to deal with the emergence of an alter personality, and has studied techniques by which the original constellation can be restored** (Braun, 1984*d*; Kluft, 1982). **It is necessary to return executive control of the body to the personality that entered the office.** Under forensic circumstances, it is inadvisable to explore a client for MPD with hypnosis without numerous special safeguards and precautions.

The diagnosis must be shared in a common-sense fashion with the client, who otherwise will be mystified by the clinician's inquiries and procedures. Explanations must be pragmatic, clarifying, and devoid of implicit suggestions that the client, in terror and/or confusion, may seize upon as implicit or explicit advices or invitations to demonstrate certain phenomena. **The usual responses are surprise, denial, or a transient sense of relief.** Anxiety and agitation may well follow the first session in which an alter emerges spontaneously or via hypnosis. The clinician must be accessible to the client during these difficult days. **Even if the sessions have been taped, the client's presenting personality may well deny the diagnosis** (Braun, 1984*d*). It suggests the intensity of the inner pain that the client has erected dissociative defenses to contain and presages the vicissitudes of the therapeutic process (Kluft, 1984*f*).

No physiological or psychological test result is a definitive diagnostic clue for MPD. However, new approaches to psychological testing, emerging from the research of Armstrong and Loewenstein (1990), offer promise. Data from ancillary sources are useful but must be scrutinized with caution, whether they confirm or disconfirm the clinician's observations or the client's recollections. It is not uncommon for family members alleged to have abused the client (or facilitated his or her abuse) to be those who have had the best opportunity to observe the client. The reliability and objectivity of their observations are suspect and may prove self-serving. It is not uncommon for hospital or law-enforcement personnel to hold strong opinions about MPD and make their observations with those opinions in mind.

DIFFERENTIAL DIAGNOSIS

In agreement with Putnam et al. (1984), in any differential diagnostic situation **the crucial issue becomes whether the client manifests alternating separate identities and episodes of amnesia or time distortion, notwithstanding**

problems with the second criterion. MPD is the only clinical entity in which both coexist and are recurrent. Inevitably, there will be cases in which the evidence for one or the other will be marginal, and a diagnosis must be arrived at by clinical judgment. If criteria are clearly present, so is MPD, and instead of "is this MPD or something else," the issues become: (1) Is the condition sufficiently well defined to fulfill DSM-III-R criteria, or should it be "technically" called a typical dissociative disorder with features of MPD, and (2) which concomitant diagnoses ought to be rendered? Clients are encountered who have the structure of MPD without a DSM-III-R level of overt phenomenology, and, as a result, are most conveniently treated as formes frustes of MPD. Also, study of the natural history of MPD shows many who at times have classic MPD exhibit less than classic manifestations most of the time (Kluft, 1985*b*). In some instances, a person should be diagnosed with MPD for clinical purposes alone but should not be enumerated as in research studies. **Bear in mind that many Axis I and Axis II entities may coexist with MPD without explaining it.** Coryell (1983) and I (1984*f*) have described the coexistence of affective disorder and MPD. I felt diagnoses were autonomous, but Coryell wondered if, at times, **MPD was an epiphenomenon of affective illness.** Many have discussed MPD as a borderline variant (Benner, 1984; buck, 1983; Clary, Burstin & Carpenter, 1984), as a narcissistic disorder (Greenwald, 1977), or have correlated it with the Briquet syndrome (Bliss, 1980). However, authors who have studied large series of clients have found the findings from single cases or small series do not hold up well when making generalizations. For example, the most extensive exploration of the relationship between borderline personality (BPD) and MPD, by Horevitz and Braun (1984), found 70% of the MPD clients also qualified for a BPD designation. Comparison of their sample with that of Kluft (1982), whose clients in general had higher ego strength, led them to conclude the presence of BPD was correlated with the clients' overall level of dysfunction, not with their MPD per se. They surmised that MPD is separate and distinct from, but may coexist with, BPD.

Most Axis II diagnoses may coexist with MPD globally or be found in an alter (Fink, 1991). Since multiple identity formation is described in BPD (Fast, 1984; Scialli, 1982; Searles, 1977), attention to amnesia becomes a critical dimension. It is also useful to **review certain qualitative dimensions of the eight DSM-III BPD criteria** (five of which must be present for the diagnosis), **comparing them in MPD and BPD but bearing in mind that both disorders can coexist.** Solomon and Solomon (1982) found **potential differences in all eight criteria.** For example, in BPD impulsivity is global, whereas in MPD impulsivity is usually circumscribed to specific personalities. In BPD, the interpersonal relationships are unstable and intense because the individual lacks a stable sense of self and object constancy. In MPD, relationships become chaotic due to the amnesia and the phenomena of MPD. In BPD, anger is constant and/or there are frequent outbursts. In MPD, anger is relegated to one or more alters, and rarely is as prevalent. The person with BPD usually attempts suicide or self-harm to manipulate others and/or relieve tension. In MPD, suicide often relates to the inner wars among the alters, masochism, and the relief of tension. The interpersonal consequences of the acts are often not considered, unless there is a therapeutic contract against self-harm.

More that 90% of MPD clients show signs of depression. Uncommonly, dissociative episodes can occur in depression (Ackner, 1954), and the disorders may coexist. Many MPD clients have been considered to be bipolar, or "rapid cyclers" at times during their clinical career. Placebolike responses to medication make an apparent cessation of dissociative signs upon initiating medication an unreliable indicator (Bernstein & Putnam, 1986). I have been impressed that the use of hypnosis to attempt to access alters and discuss the alternations that are perceived as mood swings can resolve the differential promptly in most cases. If alters are encountered, a trial of MPD therapy is indicated; if not, a pharmacological regimen should be tried. One can recheck and cross-over if clinical considerations so dictate.

Many MPD clients in my series were once diagnosed as schizophrenic. Rosenbaum (1980) suggests that has been a common phenomenon. Indeed, the hallucinations of alters' voices and presences, the alters' quasidelusional sense of separateness, and their experience of being influenced by other entities and forces overlap with schizophrenic signs (Bliss, 1984; Kluft, 1985*c*, 1987*b*, 1991*a*). **MPD clients may have brief psychotic episodes** (Coons, 1984), and **schizophrenics may have fugues** (Ackner, 1954). Coons (1984) and I (1983) concur **it is useful to look for Bleuler's primary symptoms as a guide.** A person with MPD may become withdrawn, but the other features are not found. Most schizophrenics' hallucinations are experienced as outside the head; most in MPD are perceived as within. Unlike the schizophrenic, the MPD client preserves reality testing and usually, once preliminary anxieties are resolved, establishes good rapport.

Temporal lobe epilepsy has been offered as a concomitant, a differential diagnosis, and an etiology of MPD (Schenk & Bear, 1981). Coons (1984) correctly points out that **most of the temporal lobe clients in frequently cited articles** (Mesulam, 1981; Schenk & Bear, 1981) **did not have MPD by DMS-III criteria and that clients' descriptions of alters often were not documented by the observation of dissociated personalities.** Also, the response of the ictal-MPD clients to anticonvulsants was unconvincing. Two studies (Devinsky et al, 1989; Loewenstein & Ritnam, 1988) have demonstrated that MPD and temporal lobe epilepsy are not connected in the manner hypothesized in earlier publications (Bernstein & Putnam, 1986; Loewenstein, 1991*b*). It is well, albeit often impractical, to do a full organic work-up on all dissociating individuals, including a sleep-deprived electroencephalogram with nasopharyngeal leads. Certainly **fugues, presumably organic, occur in**

78% of temporal lobe epileptics (Coons, 1984). During such states a person may wander, appear perplexed, and engage in complex stereotypic behavior. Such episodes may last from hours to a few months, and usually there is complete amnesia. Hypnosis or amobarbital as well as intense observation are useful in those cases where neither routine clinical assessment nor electroencephalography prove helpful. In one case, a hospital nurse observed a "seizure" episode and was able to engage an alter, then in control, in dialogue.

Malingering is often considered in the differential diagnosis of MPD, especially when a client's circumstances rather than his or her psychology would make the production of the symptoms of MPD useful. **A considerable number of MPD clients run afoul of the law;** antisocial behaviors by alters are far from rare. Thus, it is not unexpected that the augmentation of MPD or partial malingering of an MPD picture by a legitimate MPD client who is also a malefactor can be encountered. When a person is suspected of malingering MPD, it becomes critical to be aware when a forensic issue is involved and distinguish between the role of evaluator and therapist. The problem has been addressed at length in discussion of the Hillside Strangler Case (Orne, 1984). In practice, most malingering of MPD is crude and reveals itself by inconsistency and preoccupation with stressful circumstances that the MPD is feigned to avoid (Kluft, 1987*c*). Therefore, careful observation and corroboration from external sources become important. Malingering may be sustained under hypnosis and amobarbital. **In my experience, persons who feign MPD follow lay sources, "overstate their case," and do not maintain the consistency of their alters in areas unrelated to the motivation for their malingering.** Differential diagnosis in this difficult area remains quite problematic.

TREATMENT OF MPD

This is an exciting but confusing epoch in the history of the treatment of MPD. On one hand, an increasing number of MPD clients are being identified and are seeking psychotherapeutic help. On the other, despite the upsurge in the number of clients diagnosed as suffering from MPD, the literature on their treatment remains in a pioneering phase. The first outcome studies are quite recent(Coons, 1986; Kluft, 1982, 1984, 1986); controlled studies are not available. Many articles offer advice generalized from single cases or from small or unspecified data bases. Since MPD clients are quite diverse, it is not surprising to find citations that appear to argue both for and against many therapeutic approaches. "Multiple personality disorder delights in puncturing our generalizations, revels in shattering our security about our favorite techniques and theories, and exhilarates in the role of gadfly and disturber of the peace" (Thigpen & Cleckley, 1984). In contrast, among those workers who have seen many with MPD (and most of whom taught their techniques in workshops but were unpublished prior to the 1980s), fascinating convergences as well as differences have been noted. **Braun, observing commonalities of videotaped therapeutic behavior among experienced MPD therapists who professed different theoretical orientations, implied that the clinical realities of MPD influenced clinicians from diverse backgrounds toward similar approaches and conclusions.** He offered the hypothesis that in actual treatment settings, experienced workers behaved much more alike than their own statements would suggest (Kluft, 1984), and many authorities concur. **Many believe the prognosis for most clients with MPD is reasonably optimistic with intense and prolonged treatment from experienced clinicians.** Often logistics rather than untreatability impede success.

Despite those encouraging observations, many continue to question whether the condition should be treated intensively or discouraged with benign neglect. Concern has been expressed that naive and credulous therapists may suggest or create the condition in basically histrionic (Thigpen & Cleckley, 1984) or schizophrenic (Kline, 1984) individuals, or even enter a folie a deux with their clients (Victor, 1975*b*). Arguments to the contrary have been offered (Fink, 1991; Gruenwald; 1984*b*; Kluft, 1982, 1985*a*). In 17 years, I have seen over 600 MPD clients diagnosed by more than 425 separate clinicians in consultation and referral. In my experience, referral sources have been circumspect rather than zealous in their approach to MPD, and I **cannot support the notion that iatrogenic factors are major factors.** Although no controlled trials compare the fates of MPD clients in active-treatment, placebolike-treatment, and no-treatment cohorts, some recent data bear on the controversy. I have seen more than a dozen MPD clients who declined treatment (approximately half of whom knew the tentative diagnosis) and more than two dozen who entered therapies in which their MPD was not addressed. On reassessment two to eight years later, all continued to have MPD (Kluft, 1985*a*). Conversely, clients reassessed after treatment for MPD have been found to hold onto their gains rather well (Kluft, 1984*b*, 1986).

TREATMENT GOALS

MPD does not exist in the abstract or as a free-standing target symptom. It is found in a diverse group of individuals with a wide range of Axis II or character **pathologies** (Fink, 1991), **concomitant Axis I diagnoses, and many different constellations of ego strengths and dynamics.** Generalizations drawn from the careful study of single cases may prove grossly inaccurate when applied to other cases. **Perhaps MPD is understood most parsimoniously as the maladaptive persistence, as a post-traumatic stress disorder, of a dissociated pattern that**

proved adaptive during childhood times when the client was overwhelmed (Spiegel, 1975).

In general, the tasks of therapy are the same as those in any intense change-oriented approach but are pursued, in this case, in one who lacks a unified personality. **This precludes the possibility of an ongoing unified and available observing ego and implies the disruption of certain usually autonomous ego strengths and functions, such as memory.** The personalities may have different perceptions, recollections, problems, priorities, goals, and degrees of involvement with and commitment to the therapy and one another. Therefore, it usually becomes essential to replace this dividedness with agreement to work toward certain common goals, and to achieve unity of purpose and motivation for treatment success. **Work toward such cooperation and the possible integration of the several personalities distinguishes the treatment of MPD** from other types of treatment (Kluft, 1984*a*, *b*, 1991*b*). Although some therapists (Beahrs, 1982; Watkins & Watkins, 1988) argue multiplicity should be transformed from a symptom into a skill, rather than be ablated, most consider integration preferable.

In this lesson, the terms unification, integration, and fusion are used synonymously, and are understood to connote the spontaneous or facilitated coming together of personalities after adequate therapy has helped the client see, abreact, and work through the reasons for being of each separate alter. Consequently, therapy serves to erode the barriers between the alters and allow mutual acceptance, empathy, and identification. **It does not indicate the dominance of one alter, the creation of a new "healthy" alter, or a premature compression or suppression of alters into the appearance of a resolution** (Kluft, 1984*b*).

MODALITIES OF TREATMENT

Many pioneers in the field of MPD developed their techniques in relative isolation and had difficulty publishing their findings. For example, Cornelia B. Wilbur had extensive experience with MPD, and her work was popularized in *Sybil*, published in 1973; however, her first scientific article on treatment appeared much later (Wilbur, 1984*b*). There developed two "literatures," which overlapped only on occasion. The published scientific literature slowly amassed a body of (usually) single-case applications of particular approaches, whereas an oral tradition developed in workshops, courses, and individual supervisions, which clinicians who had worked with many cases shared their insights. This "oral literature" remained largely unpublished until several special journal issues (Braun, 1983*a*, 1984*a*; Kluft, 1984*a*).

PSYCHOANALYTIC APPROACHES:

Psychoanalytic approaches to MPD have been discussed by Wilbur (1986), Lasky (1978), Marmer (1980), Reis (1958), Kluft (in press) and Lample-de-Groot (1981). It seems clear that **some clients with MPD who have the ego strengths to undertake analysis, who are not alloplastic, whose personalities are cooperative, and who are completely accessible without hypnosis can be treated with analysis. However, they constitute a small minority of MPD clients.** Some have undergone analysis without the diagnosis being suspected; others, also undiagnosed, have had their analyses interrupted by regressive phenomena not recognized as manifestations of the MPD condition (Kluft, 1987*c*). While psychoanalytic understanding is often considered desirable in work with MPD (Kluft, 1987*c*; Wilbur, 1984), formal psychoanalysis should be reserved for a small number of cases. **Psychoanalytic psychotherapy, with or without facilitation by hypnosis, is widely**

recommended. Bowers et al. (1971) offered several useful precepts, Wilbur described her approaches (1984, 1986), and Marmer discussed working with the dreams of dissociating clients (1980). My articles (1982, 1984*a*, *b*, 1991*b*) on treatment described aspects of work in psychoanalytic psychotherapy facilitated by hypnosis, but their emphasis was on the hypnosis and crisis management aspects rather than the application of psychodynamic precepts. I have described (1984*a*, *b*) the problems and impairment of ego functions suffered by MPD clients by virtue of their dividedness, and have shown how they render the application of a purely interpretive psychoanalytic paradigm problematic.

BEHAVIORAL APPROACHES:

Behavioral treatments have been described by Kohlenberg (Ross, 1989), Price and Hess (Wilbur, 1986), and most elegantly by Klonoff and Janata (Lasky, 1978). **No doubt, behavioral regimens can make dramatic transient impacts on MPD's manifest pathology, but there is no extant case report of a behavioral regimen's effecting a successful long-term cure.** The report of a successful cognitive behavioral treatment of MPD (Caddy, 1985) is potentially misleading in that the therapy involved the use of many interventions associated with other types of therapy in addition to its use of these modalities. Klonoff and Janata found that **unless the underlying issues were resolved, relapse occurred.** Many workers think behavioral approaches inadvertently replicate childhood traumas in which clients' pain was not responded to or in which they were psychologically and/or physically confined or bound rather than allowed freedom. In fact, many clients experience them as punitive. The behavioral therapy of MPD per se currently must be regarded as ancillary rather than primary.

FAMILY INTERVENTION:

Family interventions have been reported by Davis and Osherson (1977), Beale (1978), Levenson and Berry (1983), and Kluft, Braun, and Sachs (1985). In sum, **although MPD is all too often an aftermath of family pathology, family therapy is rarely successful as a primary treatment modality. However, it often can be a valuable adjunct** (Kluft, Braun & Sachs, 1985). Empirically, treatment of an adult MPD client with a traumatizing family of origin frequently does no more than result in retraumatization. However, family interventions may be essential to treat or stabilize a child or early adolescent with MPD (Wornstein & Tyson, 1991; Kluft, 1984c). Family work may allow relationships to be saved and strengthened and may protect the children from incorporating or being drawn in to some aspects of the MPD psychopathology. In general, the concerned others in an MPD client's family may require considerable education and support. In difficult and crisis-filled cases, their support of the therapy and the therapist's support of them can be critical to the treatment's outcome. Recent publications have addressed the primary treatment issues and preferred interventions in work with the spouses of MPD clients (Panos, Panos & Allred, 1990; Sachs, Frischholz & Wood, 1991).

GROUP TREATMENT:

Group treatment of MPD can prove difficult. Caul (1984) summarized the difficulties such clients experience in and impose upon heterogeneous groups. Unintegrated MPD clients may incapacitate the group's productivity, as the materials and experiences they share may overwhelm the group members. MPD clients often are exquisitely sensitive and become engulfed in other's issues, and they are prone to dissociate in and/or run from sessions. **They work more successfully in task-**

oriented or project-oriented groups that focus on occupational therapy, music therapy, movement therapy, or art therapy (Kluft, 1984*a*). Some anecdotally describe their successful inclusion in groups with a shared experience, such as incestuous relationships, rape, or alcoholism. Caul (1984) proposed a model for undertaking an internal group therapy among the alters. Homogeneous groups of MPD clients are becoming common as more are identified. Such groups can be quite helpful as adjuncts to individual psychotherapy if structured and focused on here-and-now issues, as opposed to dealing with past traumata in detail. In the absence of such precautions, these groups can become chaotic and unmanageable (Caul, Sachs & Braun, 1986; Coons & Bradley, 1991).

AMOBARBITAL AND/OR VIDEOTAPING:

Workers have described the facilitation of treatment with amobarbital and/or videotaped interviews. Hall, Le Cann, and Schoolar (1975) describe treating a client by retrieving material in amobarbital interviews that were videotaped and then used in treatment. Caul (1984) has described taping hypnotically facilitated sessions and offered cautions about the timing of playing back such sessions to the client. **Although the personalities of some clients tolerate videotaped confrontation with evidence and alters from which they were profoundly dissociated, many people are overwhelmed by such data or re-repress it.** Such approaches are best considered on a case-by-case basis. Caul seems to advocate a version of what hypnotherapists refer to as "permissive amnesia;" i.e., the client can see the tape when ready (an analogy to the suggestion the client will remember a traumatic event when he or she is ready to do so).

HYPNOTHERAPY:

Hypnotherapeutic interventions have an established role in the contemporary treatment of MPD despite the controversy that surrounds their use. On one hand, a large number of clinicians have helped a good many MPD clients with such interventions. On the other, many prominent and eloquent individuals have raised concerns that hypnosis can concretize, exacerbate, or even create MPD. Often the debate becomes arcane to those unfamiliar with the literature of hypnosis and the specialized concerns of forensic hypnosis, in which workers struggle to guard against the induction of confabulated or false memories that are perceived as concrete reality, and, if so reported, can impede the judicial process (Orne, 1979). **Judicious hypnotherapeutic interventions, thoughtfully integrated into a well-planned psychotherapy, individualized to a particular client, and oriented toward integration, can be extremely productive and helpful, and ill-advised hypnotic work, like any other inappropriate steps, may well miscarry** (Kluft, 1982; 1991*b*; Wilbur & Kluft, 1989). The use of hypnosis has been described and documented by Allison (1974), Bowers et al. (Braun, 1984*a*), Braun (1980, 1984*d*), Caul (1984), Erickson and Kubie (1939), Gruenewald (1971), Horevitz (1983), Howland (1975), Kluft (1982, 1983, 1984*a*, *b*), Brandsma and Ludwig (1984), and Spiegel (1991), among others.

REPARENTING:

Some clinicians advocate the provision of a very tangible corrective emotional experience, under the rubric of reparenting. They undertake to create experiences within treatment that nurture the client through a more positive recapitulation of various developmental issues and to provide more positive introjects. **No**

published article addresses this approach, and my experience shows successful treatment does not necessitate such measures.

Also not available in the literature are papers on the successful approaches involving the coordinated efforts of a team of therapists employing several modalities in conjunction. This approach was pioneered by Braun and Sachs of Chicago.

USEFUL PRINCIPLES AND CAVEATS

According to an empirically-derived model, the client who develops MPD has (1) the capacity to dissociate, which becomes enlisted as a defense in the face of (2) life experiences (usually of severe abuse) that traumatically overwhelm the nondissociative adaptive capacities of a child's ego. A number of (3) shaping influences, substrates, and developmental factors determine the form taken by the dissociative defenses (i.e., personality formation). Those who remain dissociated are given (4) inadequate stimulus barriers, soothing, and restorative experiences, and are exposed to pressures and further traumatization which reinforce the need for and shape of the dissociative defenses. The elements of the Four-Factor Theory of Etiology (Kluft, 1984b) **have certain implications for treatment.** Whether or not a clinician elects to use hypnosis, he or she ought to be aware of it and of how dissociative manifestations may express themselves in clinical settings, especially as psychosomatic and quasi-psychotic presentations (Kluft, 1985*a*). The client brings his or her dissociative defenses into the therapy. One must "be gentle, gradual, and avoid imposing upon the client any overwhelming experience that is not an inevitable concomitant of dealing with painful material. The material to be recovered brings with it the certainty of reliving anguish, and explains these clients' frequent evasiveness, protracted resistances, and mistrust of the therapist's motives" (Kluft, 1984). The therapist must deal with all personalities with an "evenhanded gentle respectfulness," but help clients protect themselves from themselves. A mutuality of working together and recognition of the difficult nature of the job to be done is essential. **These treatments "sink or swim on the quality of the therapeutic alliance established with the personalities"** (Kluft, 1984).

A GENERAL OUTLINE OF TREATMENT

Virtually every aspect of treatment depends on the strength of the therapeutic alliance, which must be cultivated globally and with each individual alter. In the face of severe psychopathology, painful material, crises, difficult transferences, and the likelihood that--at least early in treatment--**the alters may have grossly divergent perceptions of the clinician and test him or her rigorously**, the client's commitment to the task of therapy and collaborative cooperation are critical. This emphasis is implicit in a general treatment plan outlined by Braun (1980, 1984*e*) that has sufficient universality to be applied in most therapy formats. **Braun enumerates 13 steps, many of which are overlapping or ongoing rather than sequential.** Alternative efforts to describe the steps or stages of therapy have been advanced by Kluft (1991*b*), Putnam (1989), and Ross (1989), among others.

Step 1: Development of **trust**; rarely complete until the end of therapy.

Step 2: Making of the diagnosis and sharing it with the presenting and other personalities.

Step 3: Establishing communication with the accessible alters.

Step 4: Contracting with the alters to attend treatment and to agree not to harm themselves, others, or the body they share.

Step 5: History gathering with each alter, **learning of their origins, functions, problems, and relations to the other alters.**

Step 6: **Solving the alters' problems** by remaining in contact, sticking with painful subjects, and setting limits.

Step 7: **Mapping and understanding the structure of the personality system.**

Step 8: **Enhancing interpersonality communications** through hypnotic interventions (Braun, 1984*d*; Kluft, 1982, 1983) or an internal group therapy approach (Caul, 1984).

Step 9: **Resolving toward a unity** and facilitating blending rather than encouraging power struggles through hypnotic or nonhypnotic approaches(Braun, 1980, 1984*d*; Kluft, 1982, 1984*b*; Wilbur, 1984).

Step 10: For integrated clients, developing **new intrapsychic defenses and coping mechanisms and learning adaptive ways of dealing interpersonally.**

Step 11: **Establishing a social network** to provide structure and support in the client's life.

Step 12: **Working through and supporting,** which is necessary for solidification of gains.

Step 13: **Follow-up**, which is essential.

THE COURSE AND CHARACTERISTICS OF TREATMENT

It is difficult to conceive of a more demanding and painful treatment, and those who must undertake it have many inherent vulnerabilities (Kluft, 1983, 1984*a*). **Dissociation and dividedness make insight difficult to attain.** Deprived of a continuous memory, and switching in response to both inner and outer pressures and stressors, self-observation and learning from experience are compromised. Alters may alienate support systems as their disruptive and inconsistent behaviors and their memory problems may make them appear unreliable at best. Traumatized families may openly reject the client and/or disavow everything the client has alleged.

The alters' switching and battles for dominance can create an apparently never-ending series of crises. Alters who identify with aggressors or traumatizers may try to suppress those who want to cooperate with therapy and share memories, or punish those they dislike by inflicting injury upon the body. Battles between alters may result in hallucinations and quasipsychotic symptoms (Kluft, 1983, 1984*a*, 1987*b*). **Some alters may suddenly withdraw the client from therapy.**

Painful memories may emerge as hallucinations, nightmares, or passive influence experiences. In order to complete the therapy, longstanding repressions must be undone, and dissociative defenses and switching must be abandoned and replaced. The alters also must give up their narcissistic investments in separateness, abandon aspirations for total control, and "empathize, compromise, identify, and ultimately coalesce with personalities they had long avoided, opposed and rejected" (Kluft, 1984*a*).

In view of the magnitude of the changes required and the difficulty of the materials that must be worked through, therapy may prove arduous for client and therapist alike. **Ideally, a minimum of two sessions a week is desirable, with the opportunity for prolonged sessions to work on upsetting materials and the understanding that crisis intervention sessions may be needed. Telephone accessibility is desirable, but firm nonpunitive limit-setting is very much in order. The pace of therapy must be modulated to allow the client respite from an incessant exposure to traumatic materials.** Some clients, once their amnestic barriers are eroded, will be in states of "chronic crisis" for long periods of time.

THE THERAPIST'S REACTIONS

Working to cure MPD can be arduous and demanding. Most therapists feel rather changed by the experience and believe their overall skills have been improved by meeting the challenge of working with this complex psychopathology. A smaller number feel traumatized. Initial reactions of excitement, fascination, overinvestment, and interest in documenting the panoply of pathology are often followed by bewilderment, exasperation, and a sense of being drained. Many feel overwhelmed by the painful material, the high incidence of crises, the need to bring to bear a variety of clinical skills in rapid succession and/or novel combinations, and the skepticism of usually supportive colleagues. Many counselors, sensitive to their clients' isolation and the rigors of therapy, find it difficult both to be accessible and to remain able to set reasonable and nonpunitive limits. They discover clients consume substantial amounts of their professional and personal time. Often the therapist is distressed to find preferred techniques ineffective and cherished theories disconfirmed. As a result, the therapist may become exasperated with some alters' failure to cooperate with or value the goals of the therapy and/or their incessant testing of his or her trustworthiness and good will.

Empathic tendencies are sorely taxed. It is difficult to feel along with the separate personalities, and to remain in touch with the "red thread" of a session across dissociative defenses and personality switches. Furthermore, the material of therapy is often painful and difficult to accept on an empathic level. **Four reaction patterns are common among therapists** (Wilbur & Kluft, 1989). **The therapist may retreat from painful affect and material into a cognitive stance** and undertake an intellectualized therapy in which he or she plays detective, becoming a defensive skeptic or an obsessional worrier over "what is real." **He or she may abandon a**

conventional stance and undertake to provide an actively nurturing corrective emotional experience. The therapist may move beyond empathy to counter-identification, often with excessive advocacy, or move toward masochistic self-endangerment and/or self-sacrifice on the client's behalf. These four stands, however they are rationalized, may serve the therapist's countertransference needs more than the goals of the treatment.

Therapists who work smoothly with MPD clients set firm but nonrejecting boundaries and sensible but nonpunitive limits. **They safeguard their practice and private lives. They know therapy may be prolonged,** thus they avoid placing unreasonable pressures upon themselves, the clients, or treatment. They are wary of accepting a MPD client they do not find likeable, because they know that their relationship with the client may become quite intense and complex and go on for many years. As a group, successful MPD therapists are flexible and ready to learn from their clients and colleagues.

HOSPITAL TREATMENT

A MPD client may require hospitalization for self-destructive episodes, severe dysphoria, fugues, or alters' inappropriate behaviors. Sometimes a structured environment is advisable for difficult phases of treatment. If the hospital staff accepts the diagnosis and is supportive of the treatment, most with MPD can be managed adequately. **Failing these conditions, a MPD client's admission can be traumatizing to the client and hospital alike.** A MPD client rarely splits a staff into various groups: on the contrary, a staff splits itself by allowing individual divergent views about this controversial condition to influence professional behavior. Unfortunately, polarization may ensue. MPD clients, especially the first few admitted to a unit, can be so overwhelming as to threaten the sense of competence of that particular milieu. The staff's sense of helplessness vis-a-vis the client can engender resentment of both the client and the admitting practitioner. The therapist should to help the staff in matter-of-fact problem-solving, explain his or her therapeutic approach, and be available by telephone.

The following guidelines emerge from clinical experience:

1. **Request a private room, which offers the client a place of refuge and diminishes crises.**
2. **Treat all alters with equal respect and address the client as he or she wishes.** Insisting on a uniformity of name or personality presence provokes crises or suppresses necessary data.
3. **Make it clear that the staff is not expected to recognize each alter. Alters must identify themselves to staff members** if they find such acknowledgment important.
4. **Anticipate likely crises with staff;** emphasize one's availability.
5. **Explain ward rules personally, having requested all alters to listen, and insist on reasonable compliance.** If problems emerge, offer warm and firm responses and eschew punitive measures.
6. Because such clients often have trouble with verbal group therapy, **encourage art, movement, or occupational therapy groups.**
7. **Encourage a cooperative therapeutic thrust despite staff member's disagreement about MPD;** emphasize the need to maintain a competent therapeutic environment for the client.
8. **Help the client focus on the goals of the admission** rather than succumb to a preoccupation with minor mishaps and problems on the unit.

9. **Clarify each staff member's role to the client,** and emphasize that all members will not work in the same way. For example, it is not unusual for clients whose therapists elicit and work intensively with various alters to misperceive staff as unconcerned if they do not follow suit, even though it usually would be inappropriate if they did so (Kluft, 1984*a*, 1991).

MEDICATIONS

It is generally agreed that **medication does not influence the core psychopathology of MPD but may palliate symptomatic distress or impact upon a coexisting drug-responsive condition or target symptom** (Kluft, 1984*a*; Loewenstein, 1991*c*). **Many clients are treated successfully without medication.** I noted (1984*a*) six clients with MPD and major depression and found treating either disorder as primary failed to impact on the other. However, Coryell (1983) reported a single case in which he conceptualized MPD as an epiphenomenon of depression. While most MPD clients manifest depression, anxiety, panic attacks, and phobias, and some show transient (hysterical) psychoses, pharmacotheraphy for such symptoms may yield responses so rapid, transient, inconsistent across alters, and/or persistent despite the discontinuation of the medication that the clinician cannot be sure an active drug intervention, rather than a placebolike response, has occurred. **Alters within a single client are known to show different responses to a single medication** (Braun, 1983*b*; Kluft, 1984*a*). Loewenstein (1991*c*) provides an authoritative overview of psychopharmacologic approaches to MPD, and is quite conservative in his estimation of the efficacy of medications. Partial rather than complete relief of target systems is most common. **With rare exceptions, medication should not be prescribed for a particular personality**. Symptoms restricted to one or a few alters are usually more responsive to psychotherapy, especially when facilitated by hypnosis. With the occasional exception of minor tranquilizers, the use of medications is most likely to be circumspect and productive when the target symptoms are shared by all or almost all of the personalities.

Hypnotic and sedative drugs are often prescribed for sleep disturbance. Many clients fail to respond initially or after transient success, and try to escape from dysphoria with surreptitious overdosage. **Most MPD clients suffer sleep disruption when alters are in conflict and/or painful material is emerging.** Often one must adopt a compromise regimen that provides "a modicum of relief and a minimum of risk" (Kluft, 1984*a*). **Minor tranquilizers are useful, but tolerance can be expected, and occasional abuse is encountered.** Often high doses become a necessary transient compromise if anxiety becomes disorganizing or incapacitating. In the absence of coexisting mania or agitation in affective disorder, or for transient use with severe headaches, **major tranquilizers should be used with caution and generally avoided.** A wealth of anecdotal reports describe serious adverse effects, and no documented proof of their beneficial impact has been published. Their major use in MPD is for sedation when minor tranquilizers fail or abuse/tolerance has become a problem. **Many MPD clients have depressive symptoms, and a trial of tricyclics may be warranted.** In cases without classic depression, results are often equivocal. Prescription must be circumspect, since many clients may ingest prescribed medication in suicide attempts. Monoamine oxidose inhibitor (MAOI) drugs give the client the opportunity for self-destructive abuse but may help atypical depressions in reliable clients. **Those with coexistent bipolar disorders and MPD may have the former disorder relieved by lithium (Lithane).** Two articles suggested a connection between MPD and seizure disorders (Mesulam, 1981; Schenk & Bear, 1981). Notwithstanding that the clients cited had, overall, equivocal responses to anticonvulsants, many clinicians have instituted such regimens. **I have**

now seen five dozen classic MPD clients others had placed on anticonvulsants without observing a single unequivocal response.

Loewenstein, Hornstein & Farber (1988) **demonstrated that clonazepam (Klonopin) can offer substantial relief to approximately half the MPD clients that suffer posttraumatic symptom complexes. Braun (1990) described the use of large doses of propranolol (Inderal) to reduce dysphoric and uncontrolled switching, but this regimen remains experimental and must be used cautiously.**

POSTFUSION THERAPY

Those who leave treatment after achieving apparent unity usually relapse within 2-24 months. Further therapy is indicated to work through issues, prevent rerepression of traumatic memories, and facilitate the development of nondissociative coping strategies and defenses. Clients often wish and are encouraged by concerned others to "put it all behind (them)," forgive and forget, and make up for their time of compromise or incapacitation. In fact, a newly integrated MPD client is a vulnerable neophyte who has just achieved the unity with which most clients enter treatment. Moritoria about major life decisions are useful, as is anticipatory socialization in potentially difficult situations. The emergence of realistic goal-setting, accurate perception of others, increased anxiety tolerance, and gratifying sublimations augur well, as does a willingness to work through painful issues in the transference. Avoidance coping styles and defenses require confrontation. Since partial relapse or the discovery of other alters are both possible, the integration per se should not be regarded as sacrosanct. **An integration's failure is no more than an indication that its occurrence was premature** (Kluft, 1982, 1984*b*).

Many clients remain in treatment nearly as long after integration as they required to achieve fusion.A detailed exploration of postfusion therapy is available (Kluft,1988).

FOLLOW-UP STUDIES

Case reports and a study of the natural history of MPD suggest **untreated MPD clients do not enjoy spontaneous remission, but instead many (70%-80%) appear to shift to a one-alter predominant mode with relatively infrequent or covert intrusions of others as they progress into middle age and senescence** (Ellneberger, 1970; Kluft, 1985*a*; Rosenbaum, 1980). Most case reports do not describe complete or successful therapies. Many that appear "successful" have no firm fusion criteria and unclear follow-up and offer confusing conceptualizations, such as describing "integrations" in which other alters are still occasionally noted. Using operational fusion criteria defined above, I have followed a cohort of intensively treated MPD clients and periodically studied the stability of their unification (Kluft, 1982, 1984*b*, 1986). The 33 clients averaged 13.9 personalities (ranging from 2 to as many as 86) and 21.6 months from diagnosis to apparent integration. Reassessed a minimum of **27 months after apparent fusion** (two years after fulfilling fusion criteria), **31 (94%) had not relapsed into behavioral MPD and 25 (75.8%) showed neither residual nor recurrent dissociative phenomena.** No genuine full relapse was noted. Of the two with MPD, one had feigned integration and the other had a brief reactivation of 1 of 32 previously integrated alters when her spouse was found to be terminally ill. Six had alters who had not assumed executive control and were classified as intrapsychic. Of those, two had new entities: one formed upon a lover's death, the other upon the client's return to college. Three clients showed layering phenomena, groups of pre-existing alters whohad been long suppressed but were beginning to emerge as other alters were solidly integrated. The other relapse events were partial relapses of previous alters under stress, but those alters remained intrapsychic. Object loss, rejection, or the threat of those experiences triggered 75%

of the relapse events. Three remain in treatment for the newly discovered layers of alters, and all are approaching integration. One individual worked years to initiate a relapse autohypnotically and only recently returned for treatment. In sum, the prognosis is optimistic for those who are offered intensive treatment and are motivated to accept it.

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QUESTIONS BASED ON THIS LESSON:

45. In multiple personality disorder, the "host personality" is

A. The one that presents itself for treatment

B. A theoretical construct denoting the identify from which the first other personality splits off

C. A term used to describe the family structure from which the client has emerged

D. The one which has executive control of the body the greatest amount of time during a given period

46. Which of the following statements is correct regarding MPD clients?

A. Direct inquiry about amnesia is never met with denial or unwitting confabulation

B. If the interview is extended up to four hours, most MPD clients will dissociate

C. Irregular school and work performance is rare in MPD clients

D. A history of child abuse is rare among MPD clients

47. In the treatment of MPD clients:

A. The prognosis is generally terrible

B. Iatrogenic factors account for the emergence and persistence of alters in most cases

C. The integration of the several personalities is the essential goal of therapy

D. Traditional psychoanalysis is the treatment of choice

48. In treating clients with MPD, which of the following reactions in the therapist can interfere with the progress of treatment?

A. Retreat from painful affect and material into a cognitive stance

B. Abandoning a conventional stance and trying to provide an actively nurturing corrective emotional experience as a primary approach to care

C. Moving beyond empathy to counteridentification, often with excessive advocacy

D. All of the above

DIRECTIONS IN MENTAL HEALTH COUNSELING

VOLUME 1
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